MORRISON
DENTAL ASSOCIATES
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912.262.6688

INFORMED CONSENT FOR TRIGGER POINT THERAPY

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent is to provide written information regarding the risks, benefits, and alternatives of the procedure named above. This material serves as a supplement to any other informed consent and to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of the muscles. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in the muscle that forms when a muscle fails to relax. The knot can often be felt under the skin and may twitch involuntarily when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain- pain felt in another part of the body or in the teeth. Scar tissue and loss of range of motion and weakness may form over time. A small needle is inserted into the trigger point, and a local anesthetic (e.g. lidocaine, procaine), botulinum toxin (e.g. Botox), or anti-inflammatory steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold, and an individualized medication program.

Initial _____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, referral to a specialist, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure, and, in this specific instance, such risks include, but are not limited to: 1. Post treatment discomfort, swelling, redness, bruising, and discoloration; 2. Post treatment infection associated with any transcutaneous injection; 3. Allergic reaction; 4. Bleeding; 5. Irritation at the injection site; 6. Skin changes; 7. The lung (or the pleura, which is the surrounding membrane) may be punctured if the procedure is performed in a muscle near the ribcage); and 8. The procedure may fail to relieve the pain symptoms. I understand the probable consequences of not receiving treatment.

Initial _____

PREGNANCY, ALLERGIES, & NEUROLOGICAL DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant. I am not lactating (nursing). I do not have any significant neurological disease, including, but not limited to, Myasthenia Gravis, Multiple sclerosis, Lambert-Eaton syndrome, Amyotropic lateral sclerosis (ALS), and Parkinson's. I certify that I do not have multiple allergies or high sensitivity to medications, including, but not limited to, lidocaine, botulinum toxin, or human albumin. .

Initial _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that are available have been fully explained to me.

Initial _____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

If treatment is discontinued during the injection appointment, payment for the services completed up to that point is expected and is the patient's responsibility.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PUBLICITY MATERIALS AND PHOTOGRAPHS

I authorize pictures to be taken before, during, and after the procedure. These pictures and digital images will become part of your record and may be used or disclosed as permitted by HIPPA. They may also be sent to your family physician or referring professional. I**nitial _____**

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I hold the doctors, healthcare professionals and Morrison Dental Associates harmless from this production. I waive my rights to any royalties, fees, and inspection of the finished production, as well as, advertising materials in conjunction with these photographs.

Initial _____

RESULTS

You may receive the following benefits. The Doctors and Healthcare professionals cannot guarantee that you will receive any of these benefits. Only you can decide if the benefits are worth the risk. Trigger point injections are used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although, there is some debate over its effectiveness. Many muscle groups, especially those in the arms, legs, lower back, and neck, are treated by this method. Trigger point injections can be used to treat fibromyalgia, tension headaches, TMJ dysfunction, migraines, and other types of orofacial pain.

Initial _____

I understand this is an elective procedure, and I hereby voluntarily consent to treatment with trigger point injections for TMJ dysfunction, bruxism, and types of orofacial pain including, but not limited to, headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me, and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure, and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I have been instructed in and understand the post-treatment instructions. I also state that I read and write in English.

_____ _____ _____

Patient Name (Print) Patient Signature Date

OFFICE USE ONLY

Health History Completed? Yes ____ No _____ Date: _____ Doctor Initial: _____

Dental/Head and Neck Examination Completed? Yes_____ No _____ Date: _____

Doctor Initial: _____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____ _____

Doctor Name (Print) Doctor Signature Date