PROLOTHERAPY INFORMED CONSENT FORM

I, _____, have been advised and consulted about the injection technique of Prolotherapy. I have carefully read the "Prolotherapy Information" handout, and have discussed any questions or concerns with my doctor.

I have been advised that Prolotherapy is an established technique used to strengthen weakened and damaged ligaments which are believed to cause pain and instability of a joint. It is also used to decrease pain and improve function in some forms of arthritis. Prolotherapy technique requires the injection of local anesthetic (Lidocaine or Procaine) and concentrated Dextrose (sugar water) into a ligament. The site of the injection is where the ligament attaches to the bone. The procedure may initially cause pain, bruising, minor bleeding, and swelling in the area of injections for one to seven days. This procedure may decrease my pain complaints, but may not completely eradicate them.

I understand the BENEFITS of Prolotherapy are decreased pain and improved function/joint stability.

I have been informed that the ALTERNATIVES to Prolotherapy are:

1. Doing nothing.
2. Surgical intervention may be a possibility.
3. Injections with steroid may also be helpful, but usually do not give lasting results.
4. Physiotherapy, massage, acupuncture, homeopathy, nutritional supplements, and manipulation.

I have been informed that the RISKS AND COMPLICATIONS of Prolotherapy are:

1. Immediate pain, stiffness, swelling, bleeding, or bruising at the injection site.
2. Allergic reaction to the anesthetic.
3. Spinal cord injury during back injections.
4. Pneumothorax (collapsed lung), when injecting near the lungs.
5. Infection at the injection site.
6. Injury to the nerves and muscles at the injection site.
7. Temporary or permanent nerve paralysis.
8. Headache, nausea, vomiting, dizziness, fainting.
9. There may be no effect from the treatment.
10. Death from complications of the treatment.

I have been informed that the risks of NO Prolotherapy are:

1. No relief of the pain.
2. Continued degeneration of the joints adjacent to ligament laxity.

I understand that this procedure is usually not covered by medical insurance, and I am responsible for the total charge myself.

_____ Date: _____
Signature of Patient/Guardian

_____ Date: _____
Signature of Physician