INTERSCALENE BRACHIAL PLEXUS BLOCK

The purpose of an interscalene brachial plexus block is to provide approximately four to twelve hours of postoperative pain reduction. The technique involves an injection into the side of the neck (interscalene) in an effort to place local anesthetic near the nerve that transmits pain from the shoulder and upper arm (brachial plexus). As this nerve lies close to other nerve, vein, and arterial structures in the neck significant complications can arise.

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of interscalene brachial plexus block have been discussed with me and may include, but are not limited to:

- *allergic reaction*
- *bleeding*
- *blood clot*
- *brachial plexus nerve damage*
- *cardiac toxicity*
- *hoarseness (recurrent laryngeal nerve block)*
- *Horner's Syndrome*
- *infection*
- *nerve damage*
- *nerve paralysis (phrenic and/or laryngeal)*
- *pneumothorax*
- *respiratory distress*
- *seizure activity*
- *spinal or epidural block*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ___________________________, M.D., with associates or assistants of his or her choice, to perform an *interscalene brachial plexus block* on ___________________________
(*patient name*)

at_____________________________.
(*name of facility*)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_______________________________ Patient or Legal Representative Signature/Date/Time

_______________________________ Relationship to Patient

_______________________________ Print Patient or Legal Representative Name

_______________________________ Witness Signature/Date/Time

Continued

3/03
Revised 9/05, 12/05, 1/06, 6/07

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).

SAMPLE

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative* *(circle one)* fully understands what I have explained.

____
Physician Signature/Date/Time

_______ copy given to patient
initial

_______ original placed in chart
initial

SAMPLE

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