

# Performance Spine & Sports Specialists, PA

## Pre-Procedure Check List

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

### Please answer the following questions.

Are you allergic to ANY medications? Yes\_\_\_ No\_\_\_  
If yes, please list: \_\_\_\_\_

Are you allergic to shellfish, iodine, contrast dye, latex gloves  
or Band-Aids? Yes\_\_\_ No\_\_\_

Do you have diabetes? Yes\_\_\_ No\_\_\_

Have you taken aspirin or aspirin containing products in the last  
3 days? Have you taken any herbal medications? Yes\_\_\_ No\_\_\_

Have you taken any blood thinners such as Coumadin, Plavix or  
Ticlid within the past 6-10 days? Yes\_\_\_ No\_\_\_

Could you be pregnant? Date of last period was: \_\_\_\_\_ Yes\_\_\_ No\_\_\_

Are you ill? (have a fever, coughing, nausea, vomiting, or diarrhea) Yes\_\_\_ No\_\_\_

**Are you being treated for an infection? Are you taking antibiotics?** Yes\_\_\_ No\_\_\_

Have you taken any medications besides Diazepam (Valium) today?  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had an x-ray guided injection before today? Yes\_\_\_ No\_\_\_

Did you sign your consent form before the procedure? Yes\_\_\_ No\_\_\_

Do you have someone to drive you home? Yes\_\_\_ No\_\_\_  
You MUST have a driver if you took Valium, Ativan, or  
Xanax before your procedure.

When did you last have something to eat or drink? \_\_\_\_\_

Where is your pain? Middle\_\_\_ Right\_\_\_ Left\_\_\_ Both Legs or Arms\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

## ANTI-COAGULANT RELEASE

Before performing your procedure today, please be aware that there is a **definite increased risk of bleeding** if you have taken Coumadin, plavix, Ticlid or similar blood thinning medications in the past 6 days for a thoracic or lumbar procedure or in the past 10 days for a cervical procedure. There is a risk, but lower, for aspirin not stopped within three days.

By signing this release, you are verifying that you have taken NONE of the mentioned medications or similar medications within the stated time frames.

NAME: (Please Print) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

## PREGNANCY RELEASE TO ALL WOMEN OF CHILD BEARING AGE (14-50)

During the procedure, we will be using fluoroscopy, which is a form of ionizing radiation (x-ray). If you are pregnant, the radiation could harm the fetus. In the early stages of pregnancy, radiation can cause malformation in the development of the body structures and cause impairment of normal function.

To the best of my knowledge, I am NOT pregnant at this time.

If I am pregnant, I agree that Performance Spine & Sports Specialists, PA and its employees shall not be responsible for any radiation risks to the fetus.

NAME: (Please Print) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_