MEDICATIONS TO BE HELD BEFORE SPINE AND MUSCULOSKELETAL PROCEDURE

We desire to maintain the highest level of safety when performing a spine or musculoskeletal spine procedure. Medications you may currently be taking may include medications which "thin blood" which may result in an increased risk for bleeding following a procedure. There may be negative consequences caused by bleeding in certain areas of your spine or body. Bleeding is a possible complication of any surgical procedure. However, recognize that another physician may have prescribed blood thinners for you, and so therefore, you may experience increased risks associated with stopping anti-coagulants (blood thinners). These risks include stroke, nerve damage, blindness, heart attack, paralysis, pulmonary embolism, deep venous thrombosis, or other "embolic" event caused by blood clots. On the other hand, continuing to take your blood thinner may increase your risk for bleeding complications.

IF YOU ARE PRESCRIBED BLOOD-THINNERS, YOU MUST COMMUNICATE WITH YOUR PHYSICIAN WHO PRESCRIBED YOUR BLOOD THINNER, AND OBTAIN THEIR PERMISSION FOR YOU TO HOLD YOUR BLOOD THINNER MEDICATION. BASED ON YOUR COMMUNICATION WITH YOUR PHYSICIAN, YOU MUST BE WILLING TO ACCEPT THE INCREASED RISK OF BLOOD CLOTSIFYOUDISCONTINUEBLOOD-THINNERS, OR BLEEDING IF YOU CONTINUE BLOOD THINNERS. EVEN IF IT IS A SMALL RISK, THERE IS A CHANCE THAT YOU MAY DEVELOP A COMPLICATION RELATED TO BLOOD THINNERS PRIOR TO AND AFTER YOUR PROCEDURE. YOUR DOCTOR WILL HELP YOU UNDERSTAND YOUR RELATIVE RISKS SO YOU CAN MAKE AN INFORMED DECISION WHETHER OR NOT TO PROCEED WITH THE PROCEDURE AND BLOOD THINNERS.

If you have decided to proceed with the procedure, after you have communicated with the Physician who originally prescribed your blood thinner, and they agreed to allow you to hold your blood thinner, please hold [stop] your medication(s) as outlined below to decrease your risk of bleeding. If certain medications are not stopped, you are responsible for telling your spine physician, and he may decline to perform your scheduled procedure due to bleeding risk. You may resume your blood thinner the night of the procedure. These recommendations also pertain to any future injections, surgeries or procedures.

DRUGS	HOLD BEFORE PROCEDURE
Aspirin (and aspirin containing medications, e.g., Excedrin, Equagesic, Synalogos-DC, and BC Powder)	**7 Days**
Coumadin (Warfarin**), Heparin/Lovenox**	**6 Days**
Anti-Inflamatory Drugs (e.g., Ibuprophen/Motrin/Aleve/Naproxen, Meloxicam/Mobic, Arthrotec, Relafen, Daypro, Advil, Celebrex)	**3 Days**
Ticlid (Ticlopidine**)**	**14 Days**
Plavix (Clopidogrel**)**	**10 Days**
Pletal (Cilostazol) and **Trental** (Pentoxufylline)	**7 Days**
Persantine (Dipyridamole), **Aggrenox** (Dipyridamole/Aspirin)	**7 Days**
Ginger, Gingko Biloba, or Fecerfew (or any herbal remedy containing these components)	**7 Days**
Orgaran (Demaparoid), **Sub-Cutaneous Heparin, Lovenox** (Enoxaparin), **Innohep** (Tinzaparin)	**5 Days**
Fragmin (Dalteparin), **Normiflo** (Ardeparin)	**at least 12 hrs.**
Vitamin E Supplementation (if, greater than 400 international units)	**7 Days**

It is valuable and necessary that you understand the information contained in this informed consent document. This consent is meant to bring to your attention that medical procedures of any type, including the treatment you consent to, come with inherent risks.

By signing this consent, you understand and agree with the following statements:

Dr. Tolman has informed me that he has only reviewed my MRI/CT images that show the
(1) intervertebral discs and foramen openings, and (2) the vertebral canal opening.
(2) Dr. Tolman has not reviewed any other MRI/ CT images or information.

I may have three treatment options.

1. One is to undergo surgical decompression first and if my symptoms indicate further intervention then to consider the intradiscal Fibrin and/or Platelet Rich Plasma (PRP) treatment.
2. A second option is to undergo the intra- discal Fibrin treatment option first, and if symptom relief is not adequate, or symptoms worsen, then undergo the spine surgery (surgical decompression or fusion).
3. A third option is intra-discal PRP first with or without intradiscal fibrin, and if symptom relief is not adequate, or symptoms worsen, then undergo the spine surgery (surgical decompression or fusion)

I understand that a goal of my treatment is to minimize the need for spine surgery, based on my MRI or CT findings, I am aware that undergoing the intra -discal Fibrin treatment, with or without PRP, or just intra-discal PRP treatment, does not necessarily eliminate my need for future spinal surgery.

I understand the risks and benefits associated with the treatment and I have chosen first to undergo the intra - discal Fibrin treatment, with or without PRP, or just intra-discal PRP treatment.

I am aware that my treatment is not a part of an FDA Fibrin/PRP/ Disc investigation. While fibrin is approved for use in many parts of the human body, Fibrin or PRP has not been approved for use in intra - vertebral discs at this time.

I understand, like most other treatments there is no guarantee regarding the outcome of the treatment.

I authorize the administration of sedation as may be deemed advisable or necessary for my comfort, well-being, or safety.

I am aware that there may be other treatment options available to me, including, but not limited to: artificial disc replacement; fusion; stem cells treatments / platelet rich plasma (PRP); therapy and exercise; pain medication; or doing nothing.

I understand the risks associated with this treatment include, but are not limited to: bleeding; infection; allergic reaction; spinal headaches; increased pain or no change to my symptoms; paralysis; pneumothorax; stroke; heart attack; weakness; potential need for further treatment; and, death.

My decision to undergo this treatment is one I made after careful consideration and is my own independent decision.

I consent to this treatment as well as any different treatment, which may be indicated during the course of this treatment, or due to any emergency.

I voluntarily presented myself to Dr. Tolman for this treatment and sign this consent and agree to save harmless Dr. Tolman and Nashville Spine Institute, neither of which assume any liability from the treatment or any risk to me.

I have received, understood and agree to the instructions and disclosures contained in: (i) the Post-Op Patient Instructions, and (ii) the Medication to be Held Before Pain Management Procedures Disclosure.

I authorize that Dr. Tolman and/or his representatives(s) record data or utilize photographic records regarding the treatment to be used for my care, medical presentations and/or medical articles. I authorize such use without compensation to me.

I understand that such data may be published by Dr. Tolman including medical journals, textbooks, scientific presentations, social media, teaching courses and internet websites. I understand that such uses may also include marketing on behalf of Dr. Tolman and that I will not be identified by name without permission.

Any information disclosed under this consent or some portion thereof is protected by Tennessee State law and the Federal Health Insurance Portability and Accountability Act of 1996 (“HIPPA”). Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

MY SIGNATURE ON THIS FORM INDICATES THAT: (1) I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THE DOCUMENT; (2) I UNDERSTAND THE RISKS, BENEFITS, AND THE OTHER INFORMATION DESCRIBED ABOVE IN THIS DOCUMENT; (3) I HAVE HAD A CHANCE TO ASK MY DOCTOR QUESTIONS; (4) I RECEIVED ALL OF THE INFORMATION I DESIRE CONCERNING THE TREATMENT/ PROCEDURE; (5) I AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE TREATMENT/ PROCEDURE.

PRINTED NAME: _____ DATE: _____

SIGN: _____