Dr. Jessica Wu, ND
12689 – 203rd Street, Maple Ridge BC

Informed consent for Prolotherapy

I, _____, hereby give consent to (Dr. Jessica Wu, ND) to perform Prolotherapy for the purpose of tightening and healing stretched or torn joint ligaments and/or muscle tendon attachments.

I understand that Prolotherapy is an appropriate therapy widely used for the treatment of ligament or tendon sprain/ strain injury resulting in joint laxity, instability, dysfunction, and pain. I understand that the components used in Prolotherapy are not generally recognized by the governing medical bodies for their use in the treatment of ligament or tendon injury and a minority of medical professionals accept the view that it is of benefit in the treatment of such disorders. I understand that the opponents consider Prolotherapy to be "experimental" but the proponents of Prolotherapy include prominent Medical clinics and Medical professionals.

I have been advised that my treating physician believes Prolotherapy has a positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to, chiropractic manipulation, physical therapy, acupuncture, braces and splints, oral antiinflammatories, steroid injections, surgical intervention, and no treatment, and these alternatives have been explained to me to my full satisfaction. I understand the benefits of Prolotherapy may be limited if I am an active smoker, live a sedentary lifestyle, take anti-inflammatory medications or glucocorticoids, or have a diet that contains an excess of calories and/or a deficiency of nutrients. I understand that I may be asked to take oral supplements between treatments and a failure to take these supplements may reduce the benefits of the Prolotherapy. I also understand that not moving the joint or applying ice to the joint in the days following treatment may also reduce the benefits of the Prolotherapy.

I understand that a series of treatments are anticipated and that these treatments may be extended over a period of months. I understand that the Prolotherapy may need to be repeated from time to time in the future in order to maintain the benefits. I understand that it is my option to stop treatments at any time without incurring further expense after I have decided that the treatments be discontinued.

I have been informed of possible risks and side effects including, but not limited to: immediate pain at injection site and lasting 3 or more days, bleeding, bruising, and/or infection at the injection site, fainting or dizziness, delayed tendinitis or muscle spasm, nausea, diarrhea, frozen shoulder, tendon rupture, spinal headache, spinal cord injury with back injections, pneumothorax with chest injections, allergic reactions to prolotherapy substances, or death from complications of treatment.

I understand there is also a risk of transient or permanent nerve injury at the site of injection. A simple dextrose solution has little, if any, associated risk of long-term nerve injury, but certain substances used in Prolotherapy do have this risk. I understand my practitioner will advise me if any of the substances having

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increased risk of nerve injury are being considered. I have provided information to (doctor name) regarding any known allergies, especially allergies to the local anesthetics Procaine and Lidocaine, phenols, and corn-based products (i.e. dextrose). I understand that this therapy should not be used if I have a severely depleted immune system, cancer in the area of injection, local infection in the Informed consent for Prolotherapy area of injection, or life threatening allergic reactions to any of the components of the injection.

I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction. I have not been asked to discontinue care with any specialists, although it is advisable to avoid high velocity adjustments to the area of treatment, as this can undo any treatment gains due to Prolotherapy and may even create further damage to the area. While I understand that there have been no warranties, assurances, or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through conversations with my treating physician, and through materials provided to me by the clinic to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy, and the procedures to be utilized, and all of my questions have been answered to my full satisfaction.

I also acknowledge that I have received a copy of this informed consent form.

Date: _____ _____

Patient's signature

_____

Patient's name (printed)

Date: _____ _____

Physician's signature

_____

Physician's name