

**New Jersey Sports Medicine and Performance Center
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Informed Consent for Prolotherapy

I, _____, have been advised and consulted about the injection techniques of Percutaneous Proliferative Reconstructive Therapy.

I have been advised that Prolotherapy is an established technique for decreasing pain, tightening of the ligaments and strengthening tendons. The technique requires the injection of local anesthetic and Dextrose into the ligament or tendon, joint capsule, or inside the joint.

I have been informed that the procedure has been used for decades and has proven safe. This procedure may initially increase pain for one to three days, similar to cortisone, and then after may alter and decrease my pain complaints, but may not completely eradicate them.

I have been informed that the alternatives to Prolotherapy are:

1. Do nothing.
2. Surgical intervention.
3. Cortisone injection.
4. Osteopathic manipulation and therapy.

I have been informed that the risks and complications of Prolotherapy are:

1. Immediate pain at the injection site.
2. Allergic reaction to the medication.
3. Bleeding.
4. Infection.
5. Rupture of tendon or ligament.
6. Injury to the nerves and muscles at the injection site.
7. Collapsed lung when injecting near the lungs.
8. There may be no effect from the treatment.
9. There may be an initial period of increased pain.

The benefits are relief or decrease in pain and improvement of function.

I understand my insurance plan may not cover expenses for this procedure and as such I will be responsible for any bill, now or later.

I understand the procedure, risks, and benefits and all of my questions have been answered.

Date _____

Patient Signature _____

Physician Signature _____

Witness Signature _____