

\_\_\_\_\_  
(Patient Name – Please Print)

## REQUEST AND CONSENT FOR EXTRACORPOREAL SHOCK WAVE TREATMENT (ESWT)

**DESCRIPTION OF PROCEDURE:** I understand that I have been diagnosed as having a painful heel or plantar fasciitis. My physician has recommended that I undergo Extracorporeal Shock Wave Treatment (ESWT). I understand that ESWT may require a local anesthetic via injections around my ankle to numb my foot during the treatment. I understand that pain medications may be given as required. I also understand that ultrasound will be used to locate and target tissue to be treated. I agree to notify my physician if I have a **Spinal Stimulator** or **Pacemaker**, and I agree that it may be turned off during my ESWT procedure. **If I believe that I may be pregnant, I understand I should not undergo the ESWT treatment.** I understand that I will be closely monitored throughout the procedure and that my physician will perform the procedure. I agree to cooperate with my physician by returning for follow-up visits in his office.

**RISKS/POSSIBLE COMPLICATIONS.** I have been advised regarding the possible risks and consequences associated with this procedure including (but not limited to) the following:

- a) ESWT may result in bruising and redness to the skin, numbness, swelling, tingling or pain at the treatment site as a result of the shock wave.
- b) I understand that this treatment could result in a tear to the plantar fascia.
- c) This treatment may or may not help your heel.
- d) Shock waves may cause damage to nerves or blood vessels.

**ALTERNATIVE TO PROCEDURE.** I understand that, in addition to doing nothing, there are alternatives to the recommended procedure, including invasive surgery as well as to continue conservative care. I have been advised of the possible risks and consequences of these alternatives as they compare to invasive surgery.

**NO GUARANTEES GIVEN.** I acknowledge that no guarantees have been made concerning this procedure.

**ADMINISTRATION OF DRUGS.** I authorize my physician to administer such drugs as may be necessary or advisable.

**PERSONS AUTHORIZED TO SIGN FOR PATIENT.** If this form is signed on the patient's behalf, the person signing certifies that he is authorized to consent on the patient's behalf. Where referenced as "I," "me," or "my," refers to the patient rather than the one who signs for the patient.

The above information has been explained to me, and I understand that my physician may be part of a group (Shockwave Specialists of the Carolinas, LLC) which owns the Epos Ultra® machine. His ownership in this technology does not affect his judgment concerning my treatment.

**CONSENT FOR TREATMENT:** I permit the Shockwave Specialists of the Carolinas, LLC and my physician, to perform the Extracorporeal Shock Wave Treatment procedure on my **left / right** foot and any necessary diagnostic tests, to treat my heel pain or plantar fasciitis as diagnosed by my physician.

I understand there is no guarantee of the effects on me or my condition as a result of treatment by Extracorporeal Shock Wave Treatment.

\_\_\_\_\_  
**Patient or Responsible Person**

\_\_\_\_\_  
**Relation to Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**