SPINE TEAM TEXAS
A TEAM APPROACH TO BACK & NECK PAIN

PRE-TREATMENT INSTRUCTIONS FOR PRP (Platelet Rich Plasma)

*****All patients will require a responsible adult driver. _____ (patient's initials)**

If you develop a fever, cold, flu, or rash, etc. prior to your appointment, you **MUST** reschedule (we WILL not treat you).

Discontinue use of any anti-inflammatory medications (steroidal and non-steroidal) ***10-14 days before*** your treatment. One of the mechanisms that makes PRP work is creating inflammation.

If you are or have been on systemic use of Corticosteroids (steroids) within 2 weeks of treatment, we cannot treat you. Consult the prescribing physician for approval to discontinue use of steroids to receive treatment.

Discontinue use of any other blood thinning agents at least ***10-14 days BEFORE and AFTER*** treatment to minimize bruising and bleeding. See below:

- Vitamin E and A Ginkgo Biloba Garlic Any Fish Oils

See attached full medication list.

It is also recommended that you avoid the following ***3 days PRIOR to your injection***:

- Alcohol Caffeine Niacin Spicy Foods

NO CIGARETTE SMOKING! Smoking is a toxin to your system and smokers do not heal well and problems can occur earlier, and patients may wait longer to experience results.

(All of these may increase your risk of bruising).

Drink at least 64oz. of water starting around 3:00PM the day prior to your treatment and continue plenty of water intake after as well.

_____

Patient Name (print) Patient Signature Date

_____

Witness Name (print) Witness Signature Date

SPINE TEAM TEXAS
A TEAM APPROACH TO BACK & NECK PAIN

(PRP) PLATELET RICH PLASMA MEDICATION LIST

The following list of medications are anti-coagulants (blood thinners) that may cause complication with your procedure and stopping them will minimize bruising and bleeding. Please review the list below and ***CIRCLE*** the medications you are currently taking and will need to stop prior to the procedure.

STOP THE FOLLOWING FOR 10-14 Days:

Advil or Motrin (Ibuprofen)
Aleve, Nuprin, Anaprox, Naprelan or Naprosyn (Naproxen Sodium)
Ansaid (Fluthiprofen)
Aspirin, Baby/Low Dose/81mg Aspirin, Bayer, Ecotrin
BC Powder, Goody's Powder, Bufferin, Excedrin (Aspirin with caffeine)
Bextra (Valdecoxib)
Clinoril (sulindac)
Daypro or Daypro ALTA (oxaprozin)
Dolobid (Diflunisal)
Feldene (piroxicam)
Fioronal (Butalbital)
Fish Oil, Omega-3, Cod Liver Oil, etc.
Ginko Biloba
High Dose Garlic
Indocin (Indomethacin)
Lodine or Lodine XL (etodolac)
Mobic (meloxicam)
Orudis, Oruvail or Ordus KT (ketoprofen)
Pletal
Ponstel (mefenamic acid)
Relafen (nabumetone)
Solaraze (diclofenac sodium)
Toradol (ketorolac)
Voltaren (diclofenac potassium)
Vitamin E
Vitamin A
Flax Seed Oil
Essential Fatty Acids (EFA's and DHA's)

DO NOT stop any of the following cardiac medications UNTIL clearance is received and instructed to do so by the prescribing doctor OR our office.

Aspirin (that is prescribed by PCP or Cardiologist)
Coumadin (Warfarin)
Effient
Eliquis
Plavix (clopidogrel)
Xarelto

Office Use Only:
Cardiac/Medical Clearance:

Required
On File
Expires on:
Requested Date:
Dr.
By:

Please speak with your physician regarding THE BELOW medication PRIOR to the procedure and clearance is needed.

Pradaxa

I have confirmed which medications I am on and understand the instructions regarding DISCONTINUING those medications PRIOR to my procedure.

For PRP, we ***WANT*** inflammation as this is one of the mechanisms of how it works!

Patient Signature Date

SPINE TEAM TEXAS
A TEAM APPROACH TO BACK & NECK PAIN

VOLUNTARY CARE PATIENT CONSENT FORM

Patient's Name _____ DOB _____

Telephone Number _____

The risks and benefits associated with platelet rich plasma (PRP), bone marrow cell concentrate, or adipose concentrate treatment procedure(s) have been explained to me.

However, I understand that no guarantee has been made to me regarding the outcome of the procedure(s).

I hereby consent to the treatment of platelet rich plasma (PRP), bone marrow cell concentrate, or adipose concentrate treatment by **Spine Team Texas** and its health care professionals and health care workers.

I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT, BY SIGNING THIS VOLUNTARY CARE PATIENT CONSENT FORM, I AM GIVING INFORMED CONSENT TO THE PROVISION OF TREATMENT WITH PROTEIN RICH PLASMA, BONE MARROW CONCENTRATE, OR ADIPOSE CONCENTRATE BY SPINE TEAM TEXAS AND ITS HEALTH CARE PROFESSIONALS, AND HEALTH CARE WORKERS AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH RELATED CLAIM AGAINST SPINE TEAM TEXAS ITS HEALTH CARE PROFESSIONALS OR HEALTH CARE WORKERS UNLESS THE ACTION OR OMISSION OF SPINE TEAM TEXAS ITS HEALTHCARE PROFESSIONALS OR HEALTH CARE WORKERS CONSITUTES WILLFUL OR WANTON MISCONDUCT.

_____ _____

Signature of Patient or Person Authorized to Consent Date

_____

Relationship (if not the patient)

**If this Consent form is signed by someone other than the patient it must be signed in the patient's presence.