Fox Valley Orthopedic Institute
Ambulatory Surgery Center

INFORMED CONSENT

2525 Kaneville Rd
Geneva, IL 60134
(630)584-1400

Adipose Derived Injection with/without PRP injection

I, ___________________________________ have been advised and consulted about the injection techniques of adipose derived injections for the treatment of Orthopedic conditions.

__________ I understand and voluntarily consent to the following procedure(s):

1. Harvesting by
    1. Fat harvesting from abdomen or low back
    2. Blood draw for PRP
2. Aspiration (drawing out) adipose tissue then centrifuge (spinning down)
3. Re-injection of my own adipose tissue back into my joint, tendon, ligament or muscle.

__________ I understand the procedure requires a follow-up visit in the office.

__________ I have been advised that the procedure may initially increase the painful area or reproduce symptoms, and then may decrease in intensity, but may not completely eradicate my symptoms.

__________ I have been informed that the procedure has been used on many patients and has been proven safe.

__________ GOALS: I understand the possible benefits of the procedure are to improve or resolve pain and/ improve function.

__________ I acknowledge that NO GUARANTEE has been given by the doctor or physician assistant nor anyone else as to the results that I may have.

__________ I have been informed that the alternatives to adipose injections are:

- Conventional Surgical Intervention
- Injection with steroids
- Physical therapy
- Continued observation

__________ I have been informed that the risks and complications of adipose harvest cell injections are:

- Immediate or delayed pain and/or stiffness at the injection sight
- Bruising or minor bleeding to harvest site or injection site
- Infection to harvest site or injection site
- Nerve, muscle or abdominal organ injury (abdomen harvest)
- Allergic reaction
- Dizziness or fainting
- Itching at the injection site
- Failure to alleviate symptoms

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__________ I understand that this procedure is usually NOT covered by insurance and I am responsible for the total agreed upon charges.

__________ I certify that I understand all the information above in its entirety, have had my questions answered, and the potential side effects explained to my satisfaction.

Patient____ Date ___________________________________

Witness _______________________________________ Date ___________________________________

Physician or Physician Assistant _____________________________________ Date _____________________