BRAINCARE PERFORMANCE CENTER | Rancho Mirage

Please click the link or copy and paste the email address below to attach and send your completed form:
rmclinic@braintreatmentcenter.com

Informed Consent for mPNS

(Magnetic Peripheral Nerve Stimulation)

Patient Name: _____

Introduction
This document is designed to provide you with information about the magnetic peripheral nerve stimulation (mPNS) procedure, a non-invasive treatment aimed at managing pain and improving nerve function. Understanding the procedure's purpose, benefits, risks, alternatives, and your rights as a patient is essential before giving your consent.

Description of the Procedure
Magnetic peripheral nerve stimulation (mPNS) utilizes magnetic fields to stimulate nerves within the peripheral nervous system, aiming to alleviate pain, enhance muscle function, and facilitate nerve recovery.

Potential Benefits
- Reduction of pain and discomfort
- Improvement in muscle functionality
- Acceleration in the recovery of nerve injuries
- May reduce and/or replace the need for pain medications

Possible Risks and Complications
Though mPNS is generally safe, there are potential risks, including:
- Possible slight discomfort or pain at the stimulation site
- Temporary muscle twitching
- Skin irritation
- In rare cases, symptom exacerbation

Alternatives might include physical therapy, medication, other nerve stimulation methods, or surgery. We encourage discussing these alternatives with your healthcare provider to identify the best approach for your condition.

NO GUARANTEES I understand there are risks involved in any procedure or treatment and it is not possible to guarantee or give assurance of a successful result.

Acknowledgment of Risk Due to Reduced Pain Sensation I understand that undergoing magnetic peripheral nerve stimulation (mPNS) may result in a reduction of pain sensation. While this is a desired outcome of the treatment, I acknowledge that reduced pain can mask injuries or conditions requiring caution or further medical attention. I am aware that engaging in activities without appropriate care or exceeding my physical limitations due to reduced pain may lead to further injury.

initials _____

Relative Contraindications and Contraindications Checklist

Please read the following statements and check "Yes" if the statement applies to you or "No" if it does not. Initial beside each response to confirm your acknowledgment.

I have metal implants (e.g., pacemakers, cochlear, orthopedic). Yes ☐ No ☐ initials _____

I have had recent surgery or injury in the area to be treated. Yes ☐ No ☐ initials _____

I have skin conditions that might be affected by mPNS. Yes ☐ No ☐ initials _____

I am currently pregnant. Yes ☐ No ☐ initials _____

I have a history of seizures. Yes ☐ No ☐ initials _____

There is a local infection near the site of pain. Yes ☐ No ☐ initials _____

Details on "Yes" Responses

If you checked "Yes" for any of the above items, please provide more details below (e.g., type of metal implant, location of recent surgery, specific skin conditions, etc.).

Details: _____

_____

_____

_____

_____

Patient Rights

You have the right to ask questions, receive clear answers, understand risks and benefits, learn about alternatives, and consent or decline the procedure. You may withdraw consent at any time before the procedure begins.

Consent

By signing, you acknowledge understanding this information, having the opportunity to ask questions, and receiving satisfactory answers. You consent to undergo mPNS, fully informed of the potential risks, benefits, alternatives, and specific contraindications.

By typing my name below, I am electronically signing this document.

Patient Signature: _____ (Patient, Parent or Legal Guardian)

Date: _____

Translated by (if applicable): _____