INFORMED CONSENT TO ORTHOPAEDIC MANUAL PHYSIOTHERAPY – CERVICAL SPINE MANIPULATION AND MANUAL THERAPY

Patient/ Guardian Initial(s)

Name of Patient: _____

Attending Physiotherapist: _____

_____ I understand that manipulation (including spinal and peripheral joints) is a skillful passive high velocity, low amplitude, minimal force thrust movement of as joint beyond its physiological limit of motion but inside the limits of its anatomical integrity for the purpose of restoring motion and function.

_____ I understand that there are **risks** associated with cervical spine manipulation and manual therapy techniques used by physiotherapists who are Fellows of the Canadian Academy of Manipulative Physiotherapy, including:

_____ 1. Exacerbation and aggravation of symptoms including increased pain and stiffness;

_____ 2. Muscle or ligament strains or sprains;

_____ 3. Muscle spasms;

_____ 4. Bruising;

_____ 5. Dizziness or vertigo;

_____ 6. Vertebral artery dissection;

_____ 7. Spinal disc injury including disc herniation and bulges;

_____ 8. Fractures;

_____ 9. Spinal cord injury , myelopathy , central cord syndrome, or quadriplegia;

_____ 10. Neurological injury or impairment including radiculopathy, paraesthesia, numbness, tingling, pins and needles, and radiating pain in an upper extremity;

_____ 11. Stroke;

_____ 12. Death.

I acknowledge I have informed my physiotherapist of:

_____ 1. All my health issues and concerns (past and present) including malignant and inflammatory diseases, suspected fractures, osteoporosis, and mental disorders;

_____ 2. All medication I am currently taking or have been prescribed including steroids and anti-clotting agents (anticoagulants);

_____ 3. All other medical professionals or treatment providers that I am currently seeing.

I acknowledge I have discussed with my physiotherapist:

_____ 1. The nature and purpose of cervical spine manipulation and manual therapy techniques;

_____ 2. The anticipated benefits of cervical spine manipulation and manual therapy techniques including reducing pain and restoring movement and function to joints;

_____ 3. **Alternative treatment options** that are available;

_____ 4. The history of my medical condition at issue, diagnosis regarding my medical condition, and treatment recommendations for my medical condition;

_____ 5. Consequences of not undertaking cervical spine manipulation and manual therapy techniques;

_____ 6. The **common and significant risks** and possible complications of cervical spine manipulation and manual therapy techniques;

_____ 7. **Serious risks** and possible complications, even if unlikely;

_____ 8. **Special risks** and possible complications, that although uncommon, may have particular relevance to me; and

_____ 9. Any questions that I may have.

_____ I acknowledge that all my questions have been satisfactorily answered.

_____ I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

_____ I acknowledge that I have the right to refuse cervical spine manipulation and manual therapy techniques, regardless of the consequences and regardless how beneficial or necessary such treatment may be.

_____ ***I consent to and authorize*** my physiotherapist, or whomever he/she may designate, to perform cervical spine manipulation and manual therapy techniques on me, and agree to proceed with such treatment.

_____ This consent applies to all my current and future treatment.

_____ I acknowledge that I have the right to withdraw my consent and stop treatment at any time.

_____ I acknowledge I have read this consent and fully understand the contents of this consent.

DATED this _____ day of _____, 20____.

_____	_____
Patient Signature	**Witness Signature**
_____	_____
Patient Name (please print)	**Witness Name** (please print)
_____	_____
Parent/Legal Guardian Signature	**Witness Signature**
_____	_____
Parent/Legal Guardian Name (please print)	**Witness Name** (please print)