# *Tequesta Family Practice*

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# IV Colchine Informed Consent Form

I Testyapatient, Testyapatient do hereby give consent to Dr. Oenbrink to perform ***intravenous colchicine therapy*** for the purpose of treatment of gout, or other painful musculoskeletal condition. I understand that intravenous colchicine is a standard therapy widely approved for the treatment of acute gout; however, its usage for the generalized treatment of other painful musculoskeletal conditions is considered an off label application of this drug , and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and is considered "experimental" by most physicians and insurance companies. I am advised that my treating physician believes that intravenous colchicine does have positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to oral anti-inflammatory medications (NSAIDS), steroids, and surgical procedures, and these alternatives have been explained to me to my full satisfaction.

I understand that the benefits of intravenous colchicine are much greater if I follow a healthy lifestyle, (nonsmoking, weight control, proper exercise, proper diet, and nutritional supplementation). I understand that an initial series of six treatments are anticipated, and that these treatments may be extended over a number of weeks. I understand that if the initial six intravenous treatments have not decreased my symptoms to an acceptable level, that it is recommended in the scientific published literature that I continue with once per week injections until the clinical signs and symptoms are ameliorated to a satisfactory degree. I have been informed that intravenous colchicine may need to be repeated from time to time in the future in order to maintain the benefits. I understand that it is my option to stop this treatment protocol at any time without incurring any further expense after I have directed that such treatment be stopped. I have also been informed that there is no guarantee that intravenous colchicine will cure or help my condition in any way.

I have been informed of possible risks and side effects including but not limited to: discomfort at the injection site, phlebitis, diarrhea, nausea, "colchicine burn" at the injection site if the vein is missed, and cramping in the small muscles of the hands or feet.

I have informed the medical personnel if I have a past history of allergy to colchicine. I understand that this therapy should not be used if I am pregnant or lactating. I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction. I have not been asked to discontinue care with any specialists.

While I understand that there have been no warranties, assurances or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and through materials provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all of my questions have been answered to my fill satisfaction. I also acknowledge that I have received a copy of this signed, informed consent.

I understand that Medicare does not pay for intravenous colchicine and may not pay for laboratory testing after this therapy has been instituted. I also understand that there are very few commercial insurance companies that will pay for intravenous colchicine for musculoskeletal conditions.

Patient's Name Testyapatient, Testyapatient Date: 01/16/2011 10:55

Patient's Signature_____

Witness:_____

Relative or Representative Relationship to patient :_____