

# INTEGRATIVE PAIN SERVICES, PA

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512-795-9977

## Pre-Procedure Instructions:

1. Do not eat or drink anything after midnight the night prior to the procedure. You may take normal morning medications with small sips of water.
2. You will be contacted with your arrival time and your payment responsibility.
3. If you would like sedation, you must have prearranged transportation home following the procedure. This cannot be from a shuttle or taxi service. Sedation and other medications will slow your reflexes and make you feel drowsy, and you should not drive under these circumstances. Your transportation must be available to pick you up as soon as you are ready to go. You will not be allowed to drive yourself home unless you do not have any sedation.
4. Discontinue all anticoagulant medications (coumadin) and aspirin products (e.g. Bufferin, Bayer, Excedrin) two weeks prior to the procedure, and all anti-inflammatory products (Advil, Motrin, Aleve, etc.) 7 days prior to the procedure, unless otherwise directed by Dr. White. This also includes Ginko Biloba and Mexican vanilla, as they have been proven to affect blood coagulation. If you are taking Metformin, please stop 1 day before the procedure. You may take your prescribed medication with sips of water the day of your procedure unless otherwise directed by Dr. White.
5. All female patients must be aware that procedures are performed using X-rays. If you are pregnant or think you might be, please inform Dr. White beforehand so that appropriate measures may be taken.
6. If you have any questions about your procedure, medications, come down with an illness/infection, run a temperature, or are for any reason unable to keep your appointment, please notify our office immediately.
7. Wear comfortable clothing, bring your glasses, if needed, for paperwork, and please leave all valuables and jewelry at home.
8. If you have any questions or concerns, please give us a call.

**I have read the above requirements and will comply with each of them as requested. I have been given a copy of these instructions.**

Patient Name \_\_\_\_\_

Signature of patient or legal representative \_\_\_\_\_

Date \_\_\_\_\_