



INFORMED CONSENT TO ORTHOPAEDIC MANUAL PHYSIOTHERAPY – THORACIC SPINE, RIB, LUMBAR SPINE, AND SACROILIAC AND PELVIC MANIPULATION AND MANUAL THERAPY

Name of Patient: _____

Attending Physiotherapist: _____

Patient/
Guardian
Initial(s)

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 thoracic spine, rib, lumbar spine, and sacroiliac and pelvic manipulation and manual therapy techniques used by physiotherapists who are Fellows of the Canadian Academy of Manipulative Physiotherapy, including:

Thoracic Spine and Rib Manipulation and Manual Therapy Risks:

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

2. Muscle or ligament strains or sprains;

3. Muscle spasms;

4. Bruising;

5. Rib injury including rib fractures;

6. Spinal disc injury including disc herniation and bulges;

7. Fractures;

8. Spinal cord injury or myelopathy;

9. Pneumothorax.

_____ Lumbar Spine and Sacroiliac and Pelvic Manipulation and Manual Therapy Risks:

- _____ 1. Exacerbation and aggravation of symptoms including increased pain and stiffness;
- _____ 2. Muscle or ligament strains or sprains;
- _____ 3. Muscle spasms;
- _____ 4. Bruising;
- _____ 5. Spinal disc injury including disc herniation and bulges;
- _____ 6. Fractures;
- _____ 7. Spinal cord injury or myelopathy;
- _____ 8. Cauda Equina Syndrome or symptoms including loss of bowel and bladder control;
- _____ 9. Neurological injury or impairment including radiculopathy, paraesthesia, numbness, tingling, pins and needles, and radiating pain in a lower extremity;
- _____ 10. Paraparesis;
- _____ 11. Paraplegia.

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 thoracic spine, rib, lumbar spine, and sacroiliac and pelvic manipulation and manual therapy techniques;
- _____ 2. The anticipated benefits of thoracic spine, rib, lumbar spine, and sacroiliac and pelvic 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 thoracic spine, rib, lumbar spine, and sacroiliac and pelvic manipulation and manual therapy techniques;
- _____ 6. The **common and significant risks** and possible complications of thoracic spine, rib, lumbar spine, and sacroiliac and pelvic 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 thoracic spine, rib, lumbar spine, and sacroiliac and pelvic 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 thoracic spine, rib, lumbar spine, and sacroiliac and pelvic 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)