

BLOOD FLOW RESTRICTION (BFR) CONSENT AND REQUEST FOR PROCEDURE

Blood Flow Restriction (BFR) Rehabilitation and Training is the brief and intermittent occlusion of venous blood flow utilizing a tourniquet system while performing exercises. This technique allows an individual to exercise with significantly reduced loads while also maintaining a hypertrophy and strength response. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: Adverse side effects are rare with this treatment. The most common adverse effects after BFR training are residual swelling in the limb, fatigued muscle(s), and/or mild soreness. These results are transient and usually resolve within 24 hours.

I have listed on page 2 my conditions, medications and contraindications which may increase BFR procedural risks.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure. Multiple treatment sessions may be required/needed. Thus, this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

I, _____, authorize The Centers for Advanced Orthopaedics Physical Therapy to administer Blood Flow Restriction (BFR) Rehabilitation.

I understand the risks and contraindications to this procedure and agree to participate in personalized BFR Rehabilitation techniques as an adjunct to my current treatment.

DO NOT SIGN UNLESS YOU HAVE READ & THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

Patient or Authorized Representative

Date

Time

Relationship to patient (if other than patient)

(Patient name printed)

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

Physical Therapist

Date

Time

I am willing to participate in or allow use of my records for research/marketing purposes? ___Yes ___No

Physical Therapy

BLOOD FLOW RESTRICTION (BFR) CONSENT
(continued)

If you have any of the following conditions, please check all that apply:

- Arterial Calcification
- Abnormal clotting times
- Diabetes
- Sickle cell trait
- Tumor
- General Infection
- Hypertension
- Cardiopulmonary conditions
- Renal compromise
- Clinically significant acid-base imbalance
- Atherosclerotic vessels
- Pregnant

If taking any of the following medications, please check all that apply:

- Anti-hypertensive medications
- Creatine supplements

If you have any of the following contraindications, please check all that apply:

- Venous thromboembolism
- Impaired circulation or peripheral vascular compromise
- Previous revascularization of the extremity
- Extremities with dialysis access
- Acidosis
- Sickle cell anemia
- Extremity infection
- Tumor distal to the tourniquet
- Medications and supplement known to increase clotting risk
- Open fracture
- Increased intracranial pressure
- Open soft tissue injuries
- Post-traumatic lengthy hand reconstructions
- Severe crushing injuries
- Severe hypertension
- Elbow surgery (where there is concomitant excess swelling)
- Skin grafts in which all bleeding points must be readily distinguished
- Secondary or delayed procedures after immobilization
- Vascular grafting
- Lymphectomy
- Cancer explain: _____