KENTUCKY
ORTHOPAEDICS & SPINE

Patient Name: _____ Date of Birth: _____

Medication: _____ Prescribing MD: _____

An **Epidural Steroid Injection** has been recommended for the above patient. Please indicate whether he/she **can or can not** discontinue the prescribed blood thinner prior to the injection.

The patient will be instructed to resume their normal schedule for blood thinner following the Epidural Steroid Injection.

- ☐ **YES**, the patient may **DISCONTINUE** their blood thinner for ____ days.
- ☐ **NO**, the patient may **NOT** discontinue their blood thinner for ____ days.

Provider Signature: _____ Date:_____

Please check the box of which medication you are prescribed below.

- ☐ Heparin
- ☐ Dalteparin/Fragmin
- ☐ Lovenox/Enoxaparin
- ☐ Xarelto/Rivaroxaben
- ☐ Eliquis/Apixaban
- ☐ Pradaxa/Dabigatran
- ☐ Coumadin/Warfarin- must have PT/INR 1 day prior to injection
- ☐ Aspirin or baby Aspirin
- ☐ Other

Please fax this form back to 859-737-0070. Feel free to contact our office at 859-737-5333 with any questions.