WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Consent − Procedure

CONSENT FOR INVASIVE CARDIOVASCULAR PROCEDURES

I hereby authorize Dr. _____and/or his associates to diagnose and/or treat the condition: _____ and to render appropriate post−catheterization care.

The procedure necessary to diagnose my condition has been explained to me by Dr_____ and I understand the nature of the procedure to be: place catheters into and near the heart to measure pressures; and inject contrast into the heart and vessels to obtain x−ray pictures. I understand that an intravenous line will be started before the procedure and that I might receive intravenous sedation.

I understand that if a blockage is found that can be treated by Balloon Angioplasty and/or Stent placement, I agree to have an Interventional Cardiologist perform the procedure as an extension of the original procedure.

It has been explained to me that during the course of the catheterization unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in the above paragraph. I authorize the above named physician and his designees to perform such additional procedures as are necessary and desirable in their professional judgement. These procedures may include but are not limited to administration of drugs and placement of an intra−aortic balloon, and possibly the use of a stent system approved by the FDA under a Humanitarian Device Exemption.

I REQUEST THE ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS IF NECESSARY IN THE JUDGMENT OF THE ANESTHESIOLOGIST OR SURGEON. I understand the potential need for a blood transfusion and available alternatives. I understand that the transfusion of blood is associated with risks that cannot be completely avoided, even by the most careful modern blood banking techniques. These risks include, but are not limited to transmission of infectious disease, particularly hepatitis and acquired immune deficiency syndrome, and the possibility of severe transfusion reactions. These reactions may produce fever, hives, or more serious reactions such as shock and/or kidney shutdown.

If the administration of local anesthetics, sedatives and painkillers is deemed necessary in the judgment of the physician performing the procedure, I understand this will produce a general state of sedation during the procedure; and that the potential complications of these medications can include lowering of blood pressure, reduction in breathing and blood oxygen, airway obstruction, and heart rhythm disturbances.

I have been made aware of certain risks and consequences that are associated with the procedure. These include: bleeding, infection, allergic reaction to dye, vascular injury, myocardial infarction (heart attack), change in rhythm (cardiac arrest), stroke, kidney failure, and death. I have been made aware of the risk of blood collection around the heart which may require urgent drainage procedure. I have been made aware of possible need for intraaortic balloon pump placement or referral for emergent open heart surgery. If I receive intravenous sedation, additional risks include: changes in respiration, changes in blood pressure. I have also been made aware of the potential benefits of and alternatives to the procedure.

I acknowledge that no guarantee has been made to me concerning the results of the catheterization. I accept the risks and consequences of the procedure.

I hereby authorize Wentworth−Douglass Hospital to retain, preserve and use for teaching and/or quality assurance purposes films taken and blood pressures recorded during my catheterization. I authorize the release of identifiable information for quality improvement activities including name, social security number, and date of birth pertaining to the American College of Cardiology National Data Registry and the Northern New England Cardiovascular Disease Study Group data registry provided that the identifiable information is not disclosed for publication for scientific, educational, or professional purposes.

I consent to release my films and medical records pertaining to this procedure, or previous to consulting physicians.

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

_____ _____
Signature of Patient Date / Time

_____
Physician's Signature

If patient is unable to sign or is a minor, complete the following. **Patient is unable to sign because:**_____

_____ _____ _____
Signature of Closest Relative or Legal Guardian Date / Time Relationship to Patient

_____ _____ _____
Witness (as appropriate) Date / Time Physician's Signature