HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

CONSENT FOR CARDIAC CATHETERIZATION, CORONARY ANGIOGRAPHY AND CORONARY ANGIOPLASTY/STENT

SH 419CC MR

419

☐ Inpatient
☐ Outpatient
☐ ED

Patient Name: _____ DOB: _____

RR DONNELLEY

I hereby give my consent and authorize

_____

(The list of possible assistants, all of whom are privileged to provide surgical services at the hospital, is available)

to treat the following conditions:

_____

by performing the following procedure(s) (when appropriate, specify site and laterality; for serial procedures, indicate expected frequency and duration, not to exceed one year):

Cardiac catheterization and coronary angiography: *A thin, hollow plastic tube (catheter) will be inserted into a peripheral artery and/or vein following local anesthesia with Lidocaine. The catheter will be advanced under x-ray guidance to the various chambers of the heart to measure pressures, and dye will be injected to assess heart function and wall motion. Dye will also be injected into the coronary arteries to assess the presence, location, and severity of coronary artery disease.*

Coronary Angioplasty/Stent: *A catheter with an inflatable balloon at the tip will be passed through the larger guiding catheter into the coronary artery until the balloon is in the middle of the blockage. The balloon will be inflated to dilate the obstructed area. In some circumstances, coronary atherectomy may be done in which a catheter is placed in the artery, and the blockage is removed using the cutting device. In some instances, a coronary stent may be placed in the artery with or without the use of an ultrasound (sonographic) catheter for guidance. A pacing or pressure monitoring catheter may also be passed to the right side of the heart via a large vein prior to starting the procedure.*

1. The care provider has explained my condition to me, the benefits of having the above treatment procedure, and alternate ways of treating my condition. I understand that no guarantees have been made to me about the result of the treatment. The alternatives to this procedure include:
   Not performing the procedure.

2. The care provider has discussed with me the reasonably foreseeable risks of the treatment and that there may be undesirable results. The risks that are specifically related to this procedure include:
   The need for transfusion of blood and/or blood components, bleeding, infection, blood clot formation, stroke, heart attack, abnormal heart rhythm, damage to the blood vessel, allergic reaction to the dye, radiation induced skin injury, kidney failure, puncture of the lung, death.

3. I understand that during the treatment a condition may be discovered which was not known before the treatment started. Therefore, I authorize the care provider to perform any additional or different treatment which is thought necessary and available.

4. I consent to the administration of local, regional or general anesthesia and/or sedation as deemed most appropriate for the procedure to be performed. (The list of possible anesthesia providers, all of whom are credentialed to provide anesthesia at this hospital, is available).

5. Any tissue, parts, or substances removed during the procedure may be retained or disposed of in accordance with customary scientific, educational and clinical practice.

6. If a vendor representative is expected to be present during my procedure, it has been explained to me that the vendor representative works for: _____ (manufacturer of the device to be used) and that his/her role includes: ☐ helping the doctor/OR staff choose, prepare, use any device, ☐ provide info regarding the device, ☐ other, including any hands on assistance (describe): _____.

   I consent to the vendor representative's presence and involvement as described. If circumstances change and a decision is made during my procedure that a vendor representative's presence is needed, I will be notified of the above after my procedure is completed.

SMH-Consents
HH-Consents

(continued on back)

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SH 419CC MR

Patient Name: _____ DOB: _____

7. **Patient Consent for Medical or Surgical Procedure: I have carefully read and fully understand this informed consent form, and have had sufficient opportunity to discuss my condition and the above procedure(s) with the care provider and his/her associates, and all of my questions have been answered to my satisfaction.**

Patient Sign here →

_____ Signature of Patient

_____ Date Time

_____ Signature of Parent or Legal Guardian (if Patient is unable to sign or is a minor)

_____ Relationship to the Patient

Complete this section for all OR procedures and all other invasive internal procedures performed in any setting.

8. **Consent for Receipt of Tissue(s):**
   - ☐ yes (please list), _____
   - ☐ not expected to be needed, but may be required and given in an emergency
   - ☐ refused
   - ☐ n/a

9. **Consent for Blood Transfusion:**
   - ☐ yes
   - ☐ not expected to be needed, but may be required and given in an emergency
   - ☐ refused. Refer to SMH Policy 9.18 (Refusal of Blood (or Blood Products) Transfusions or HH Policy 4.1 (Blood Transfusion-Refusal to Permit).
   - ☐ n/a

   For procedures that have the potential for significant blood loss and instances where blood products may be required in an emergency, I consent to the transfusion of blood or blood components that may be necessary before, during, or after the procedure. I have been informed that transfusion is not 100% safe. Risks include lung injury, fluid overload, rash, fever, chills, allergic reaction, weakened immune system, infection from bacteria, viruses, or parasites, including but not limited to HIV (the AIDS virus) and hepatitis, and death. I have discussed possible alternatives with my care provider, including no transfusion, autologous (my own blood) donation, cell salvage, drugs which cause my body to make more blood, and drugs which can decrease bleeding. I understand that these alternatives may not be available due to timing or health reasons and the above risks may still apply.

10. **Patient Consent for Blood/Tissue: I have had a chance to discuss the risks, benefits and alternatives regarding transfusion/receipt of tissue (as above) with my healthcare provider. My decision(s) regarding the transfusion of blood or blood components and/or the receipt of tissue are as above. I understand this covers my perioperative/periprocedural (before, during, and after the surgery/procedure) course of treatment.**

Patient sign here unless 8 and 9 n/a →

_____ Signature of Patient

_____ Date Time

_____ Signature of Parent or Legal Guardian (if Patient is unable to sign or is a minor)

_____ Relationship to the Patient

ATTESTATION

I have discussed the planned procedure, including the potential for any transfusion of blood products or receipt of tissue as necessary, expected benefits, the potential complications and risks and possible alternatives and their benefits and risks with the patient or the patient's surrogate. In my opinion, the patient or the patient's surrogate understands the proposed procedure, its risks, benefits, and alternatives.

Provider Sign here →

_____ Signature of Care Provider

_____ Date Time

_____ Printed name and title