

## Bethesda Hospital East

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## Bethesda Hospital West

9655 Boynton Beach Blvd  
Boynton Beach, FL 33472  
(561) 336-7000

### CARDIOVASCULAR LABORATORY CONSENT

PATIENT:

I here by authorize Doctor(s)

to perform upon

the following procedure or operation:

**Cardiac/Peripheral Catheterization and Angiography;** this procedure involves the passage of catheters through blood vessels in the groin/arm. Pressure measurements are recorded and contrast (dye), are injected to look at the arteries for blockage.

Based upon the diagnostic findings, the following procedures may also be performed:

**Coronary Peripheral Angioplasty** involves the opening or dilating the passageway of a narrow artery.

**Stent Implantation** involves placing a balloon catheter with a wire mesh scaffold (stent) over it into the artery to support the wall and assist to reduce the amount of blockage. The balloon is removed and the stent remains permanently within the artery.

**Intravascular Ultrasound** involves passing an ultrasound catheter into the artery for the purpose of studying details of the interior of the artery.

**Percutaneous Transluminal Coronary/Peripheral Angioplasty** involves using a catheter with a small balloon at the tip that is inflated at the blocked area of artery stretching the artery and flattening the plaque against the artery wall.

**Rotational Arthrectomy** involves passing a catheter with a football shaped tip coated with microscopic diamond crystals into the artery. The tip is driven by a turbine at very high speed. The plaque particles that are removed are typically smaller than red blood cells and therefore move downstream and are picked up by the body's waste system.

**Hemolytic Thrombectomy** involves the passage of ultrasound catheter that removes fresh clot in an artery by the vacuum produced by a high-speed saline flush.

I understand that this procedure is done under local anesthesia. Small tubes (catheters) are placed into blood vessels of the groin by means of a small incision or vessel puncture with needles. The tube is then passed through the blood vessels until it enters and traverses the proper chambers of the heart. Through this catheter, I will receive x-ray contrast material for the purpose of enhancing the coronary arteries and coronary structures, for a more complete diagnostic and/or interventional study.

There are certain risks, hazards, complications and consequences associated with these procedures that may occur even when the procedure is performed flawlessly and with the greatest care. These risks or complications include fainting, very slow or fast heartbeat, infection, loss of blood requiring transfusion, tamponade, perforation of blood vessels, allergic reactions, blockage of a groin blood vessel requiring emergency surgical procedure to restore circulation, heart attack, heart failure, rarely loss of limb, stroke, brain death, blood clots or death. I understand and accept all such risks or complications.

Patient Name:		Patient#:	
MR#:		Attending Physician:	
Admission Date:		DOB:	
Gender:		Age:	

This procedure usually requires moderate sedation. I understand that the expected result of moderate sedation is reduced anxiety and/or pain, partial or total amnesia. The drug is injected into the blood stream. I understand that the risks associated with moderate sedation are unconscious state and depressed breathing, possibly requiring intubation. I consent to the administration of moderate sedation.

This procedure and its complications have been explained to me, I acknowledge that I have been given no guarantee against complications or assurance of success by the physician who has explained them. I know I have been given free choice to accept or reject any and/or all of the procedures to be performed on myself. In the event any complications should arise. I permit the above physicians to seek consultation with other specialties and permit the performance of any surgical or other procedures that may be required on an emergency basis to correct such complications.

The nature of my conditions; the purposes and techniques of the proposed procedure(s); and the risks have been explained to me by my physician. In addition, the physician has explained to me that there are alternative ways of treating my condition but I have chosen this procedure.

**I UNDERSTAND that no guarantees have been made to me that this operation will improve my condition.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

(PATIENT SIGNATURE)

Patient is unable to sign because:

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

(If patient unable to sign, person authorized to sign.)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

(Witness to Signature or Telephone Consent Only)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

(Second Witness to Telephone Consent Only)

Interpreted By:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

(Interpreted By)

Patient Name:		Patient#:	
MR#:		Attending Physician:	
Admission Date:		DOB:	
Gender:		Age:	