Consent To Cardiac Catheterization And Possible Intervention

1. **Permission.** I authorize Dr. _____ and his/her associates or assistants at this healthcare facility to perform a catheterization including such photographing, videotaping, televising or other methods of visually recording the procedure(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my (the patient's) identity will remain anonymous.
2. **Explanation of procedure(s), risks, benefits and alternatives.** Catheterization is an invasive procedure requiring entering into one or more blood vessels of the body. Most commonly it involves administration of contrast with x-ray imaging. After the diagnostic portion of the procedure one of the following options will be considered:
   1. Further diagnostic testing
   2. Medical therapy
   3. Intervention to blood vessel, which may include placement of a catheter, balloon or stent.
   4. Consideration of cardiac surgery

   Dr. _____ has fully explained to me the nature and purpose of the procedure(s) and has also informed me of expected benefits and complications (from known causes), attendant discomforts and the risks that may arise including but not limited to death, stroke, heart attack, vascular injury, arterial occlusion, chronic pain syndrome, neurologic damage, bleeding, allergic reaction to contrast and infection, as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered full and satisfactorily.
3. **Anesthesia.** I understand that anesthetics, sedatives or analgesics (as may be considered necessary) and the type, will be explained to me along with the risks, benefits and alternatives by a representative of the anesthesia team or other credentialed practitioner providing sedation/anesthesia services at this healthcare facility prior to the surgery.
4. I further consent to the administration of blood or blood products as may be considered necessary. I recognize that there are always risks to health associated with the administration of blood or blood products and such risks have been fully explained to me.
5. **Refusal of Blood Products.** I refuse transfusion of packed red cells, platelets, plasma or white blood cells even if such refusal will result in my death.

   ****Patient's signature: _____ Date: _____ Time: _____**
6. **Specimens.** Any organ and/or tissue surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such organ and/or tissue may be disposed of in accordance with customary practices and applicable State laws and regulations. Post pathology gross examination and six weeks after final diagnosis, organ and/or tissue may be transported to Hofstra North Shore-LIJ School of Medicine to be used for medical student training and scientific research purposes.
7. **Understanding of this form.** I confirm that I have read this form, fully understand its contents, and that all the blank spaces above have been completed prior to my signing. I understand that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) described above.

_____	_____	_____	_____
Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient
_____	_____		
Telephonic Interpreter's ID #	Date / Time		
OR			
_____	_____	_____	_____
Signature: Interpreter	Date / Time	Print: Interpreter's Name and Relationship to Patient	
_____	_____	_____	_____
Witness to signature (Signature)	Date / Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient. If applicable, I certify that outside pathology slides have been reviewed by the Hospital's Pathology Department.

_____	_____		
Responsible Practitioner's Signature	Date / Time		
_____		_____	
Print Responsible Practitioner's Name		Contact Information	

Patients refusing blood products **must sign this form and complete "Refusal Of Consent To Blood And Blood Products" form # VD003.

If patient consents to blood products "N/A" **must** be indicated in this signature line.