UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &MR#

CONSENT FOR CEREBRAL ANGIOGRAPHY WITH OR WITHOUT ANGIOPLASTY WITH OR WITHOUT INTRA-ARTERIAL ADMINISTRATION OF MEDICATION FOR TREATMENT OF VASOSPASM WITH OR WITHOUT VASCULAR CLOSURE DEVICE AND ADMINISTRATION OF ANESTHESIA OR SEDATION

A. CONSENT FOR PROCEDURE

1. I authorize_____to perform the following procedure(s):

CEREBRAL ANGIOGRAPHY WITH/WITHOUT ANGIOPLASTY WITH/WITHOUT ADMINISTRATION OF INTRA-ARTERIAL MEDICATION FOR TREATMENT OF VASOSPASM WITH/WITHOUT VASCULAR CLOSURE DEVICE.

_____

INDICATE LOCATION AND LATERALITY, RIGHT OR LEFT, IF APPROPRIATE

I understand that I may need urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. These practitioners may perform significant surgical tasks including: opening and closing incisions, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges. Residents will only perform all or parts of the procedures under the supervision of my doctor.

2. I understand my diagnosis/condition to be: **SUBARACHNOID HEMORRHAGE INDUCED VASOSPASM.**

3. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed.

4. I have been told about and understand the risks and benefits of the procedure(s) listed above. I understand that there are risks for all kinds of surgery. These risks, which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may result in paralysis, cardiac arrest, brain damage, and/or death. other risks for this procedure may include: **ALLERGIC REACTION TO CONTRAST OR MEDICATION, BLOOD VESSEL INJURY OR THROMBOSIS, RENAL INSUFFICIENCY, KIDNEY FAILURE, STROKE, VESSEL DISSECTION/RUPTURE, DISTAL EMBOLI, DEVICE FAILURE, REPERFUSION HEMORRHAGE, RADIATION EXPOSURE SKIN CHANGES, IRRITATION, AND/OR HAIR LOSS.**

5. I understand the alternatives to the proposed procedure and the related risks to be: _____

_____

6. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.

7. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.

8. I understand that any tissues or parts removed during my procedure may be disposed of by the hospital or used for any lawful purpose including education and research.

9. I consent to the above as a series of the same treatment over period of time from__/__/__ through this hospital stay. I understand that if this procedure needs to be repeated during this hospital stay, any of the physicians identified above may perform the procedure.

(CONTINUED ON NEXT PAGE)

UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &MR#

B. CONSENT FOR ANESTHESIA OR SEDATION

1. When local anesthesia and/or sedation is used by the physician on page one, Section A1:

I consent to the administration of such ***local anesthetics*** as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

I consent to the administration of ***sedative medications*** by or under the direction of the physician named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

---

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the **Department of Anesthesiology:**

I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic ("being put to sleep") and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO THE PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative
☐ 2. Guardian ☐ 5. Parent ☐ 8. **Other****
☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

***Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.**

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	DATE	TIME

SIGNATURE OF WITNESS (OPTIONAL) REQUIRED FOR TELEPHONE CONSENTS	PRINTED NAME	DATE	TIME

E. INTERPRETER ATTESTATION (when applicable)

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID#	PRINTED NAME	DATE	TIME