



Consent / Authorization for Catheterization Laboratory Procedure(s)

1. I consent to allow Dr. Richard Sola, Dr. Douglas Spriggs, Dr. Bernardo Stein, Dr. Aland Fernandez, Dr. S. Masood Gilani, Dr. Donald Kikta, and/or Dr. Jayendrakumar Patel to perform the following procedure(s) referred to as: **Cardiac Catheterization and/or Percutaneous Coronary Intervention, Possible Vascular Angiography, Possible Insertion of Intra-Aortic Balloon Pump**, and to perform additional procedures, which in their judgment, may become necessary.

2. **Unforeseen conditions:** I understand during the procedure or the course of the operation, unforeseen conditions may arise, which necessitate procedures different from or in addition to those we have discussed. I consent to the performance of additional operational procedure that the above-named physician and his associate or assistant may consider necessary. I agree to an emergency procedure if indicated.

3. **Anesthesia:** I further consent to administration of such anesthesia and conscious sedation as may be considered necessary to reduce the anxiety and discomfort associated with this procedure. This will be provided by a Registered Nurse under the guidance and direct supervision of your physician. Alternatively, I may request in writing for the provision of these services by a nurse practitioner. I recognize that there are risks to life, death and health associated with conscious sedation and anesthesia.

4. **Benefits, risks and alternatives to proposed treatment plan have been discussed.** The physician and his associates have fully explained to me the nature of the proposed procedure and its expected benefit as well as alternatives. Additionally, I completely understand that my procedure carries risks which may include, but are not limited to, the possibilities of death, stroke, heart attack, damage to the nerves or blood vessels of the arm or leg, kidney failure, allergic reactions and serious bleeding events. I have been given the opportunity to ask questions and I have had all of my questions answered to my satisfaction.

5. **Surgical risk:** I also understand and have been informed that there are risks to the performance of any surgical procedures such as severe blood loss, infection, cardiac risks and others including stroke and death. I am aware of the practice of medicine and that surgery and the administration of medical care is not exact science. I agree that no guarantees have been made to me as to the result of the operation or procedure described above.

6. **Educational observation:** I consent to the admittance of observers. I also consent to the use of photographs and other material for scientific purposes provided my identity is not revealed.

7. **Patient certification:** I confirm that I have read or have had read to me and understand the above document. I have been given the opportunity to ask and have had my questions answered to my satisfaction. I am of sound mind and due influence and I am competent to make this decision and do so of my own free will. I have no further questions. I consider treatment of procedure as proposed by my physician.

8. **Discharge/Transfer:** I understand that I am scheduled to go home after this procedure and that I must have a responsible party to drive me home. In the event that my physician should deem it necessary or advisable, I consent to my transfer to a hospital or other healthcare facility and permit the sharing of all records pertaining to that admission between CCC Outpatient Cath Lab and the receiving facility.

9. I consent to HIV, Hepatitis B virus, or Hepatitis C virus testing in the event the physician or department personnel have an accidental exposure to my blood or body fluids during my treatment.

10. I consent to fluids as deemed necessary, and to the transfusion of blood or blood components deemed necessary.

11. I consent to the release of medical information necessary for billing, collections, and in order to provide a continuity of care. A photocopy of this consent will be considered as effective as an original.

12. I understand that it is my right to have an Advance Directive/Living Will. This facility has made it clear to me their policy, on the basis of conscience, to initiate all life saving measures in the event that my condition deteriorates. Such measures will continue through transfer procedures to a facility that will comply with my directive or treatment decisions.

PATIENT/RELATIVE/GUARDIAN SIGNATURE	PATIENT NAME	DOB	MR #	DATE	TIME
WITNESS SIGNATURE	WITNESS NAME			DATE	TIME