Extremity Venogram and Intervention Procedure and Sedation Consent

I (Patient Name), ______________________________ authorize Dr(s). ______________________________

To do (medical/lay terms):

☐ Extremity venogram with possible balloon angioplasty and or stent placement

☐ Possible clot lysis and/or thrombectomy

☐ Removable IVC filter placement or removal

☐ Sedation

The **nature and reason(s) for the procedure** have been discussed with me. The potential **risks, benefits and side effects** have been explained and any **potential problems that may occur during recuperation**. I understand the reason(s) and benefits for the procedure are: Blood clot or venous insufficiency.

RISKS:

Please have the following inform I know about the following problems which may occur: ation ready:

- Bruising, redness, swelling and/or infection in the tissue or bone around the area of the procedure or other parts of the body.
- Internal and/or external scarring may occur.
- Opening of the puncture site or blood vessels after the procedure.
- Damage to nerves at or near the procedure area which may result in numbness, pain, paralysis or other dysfunction of parts of the body or organs.
- Embolization of clots to the lungs or other extremities. (Deep vein thrombosis, or DVT)
- Bleeding and/or loss of blood requiring blood transfusion.
- The heart rate may change, become irregular, stop or a heart attack may occur.
- Blood pressure may change, resulting in stroke or death.
- Blood vessels in the procedure area or elsewhere may be damaged or plugged.
- Kidney failure.
- Removing the IVC filter may not be possible and may remain implanted in the body.
- Allergic reactions to medications, including sedation or contrast media used for imaging.
- Use of sedation carries the risks of respiratory depression, low blood pressure and nausea and vomitin

These risks can be serious, extending the hospital stay, and can possibly be fatal.

ALTERNATIVES:

Other methods of treatment with **risks, benefits and side effects**, including not having this procedure, have been discussed with me and this is the method I have chosen.

ADDITIONAL PROCEDURES:

I understand that during the procedure problems may arise requiring a procedure, different than what is listed above. If another procedure is needed, I authorize my doctor to do whatever procedure is considered to be in my best interest.

GUARANTEE and LIKELIHOOD OF ACHIEVING GOALS:

I understand that no guarantee has been made and that the procedure may not cure my problem or enable me to reach my desired goals.

OTHER PRACTITIONERS:

I understand that other health care practitioners and allied health professionals may participate in this procedure **and perform tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been credentialed or privileged.**

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AHVC
ADVANCED HEART & VEIN CENTER

VISITORS/PHOTOGRAPHY:

I understand that students (medical, nursing or allied health) and/or health care industry representatives may be present to observe my procedure. I also understand that my procedure may be photographed or videotaped for purposes of documentation.

TRANSFUSION CONSENT: can be used with a procedure (above) or independently (complete patient name and the following)

TRANSFUSION OF BLOOD OR BLOOD PRODUCTS:

The doctor has informed me that it may be necessary to receive blood or blood products in connection with my care. Blood transfusions with blood products such as plasma, platelets or packed cells are used to treat acute blood loss from disease or surgery, acute and chronic anemia, and other conditions. The potential risks, benefits, and alternatives of transfusion, including what could happen if refused have been explained and I understand them. I understand that transfusions can be done with blood donated by others (homologous), from someone I chose (directed), or with my own blood (autologous). I have been informed that extensive donor screening and testing are performed on the blood products. I am also aware that blood is tested for HIV, Hepatitis C, Hepatitis B, HTLV-1/11, and West Nile. I understand the reactions and risks described to me by the doctor and that the reactions and risks exist in spite of the fact the blood has been tested. Common reactions include fever, chills, hives and iron overload. Infrequent reactions include mild allergic, lung injury (TRALI), fluid overload (TACO) and bacterial infection. Rare reactions included a severe reaction, graft vs. host disease, acute or delayed hemolytic and death. I understand the purpose of the transfusion of blood or blood products is **FOR CURRENT DATE OF SERVICE ONLY**. I understand that if blood transfusion is required, I will be transferred to the hospital. I understand the alternatives to blood transfusion including what could happen if the transfusion is refused.

PLEASE INITIAL (Pt. to initial only if applicable and recommended by physician):

can be used with a procedure (above) or independently (complete patient name and the following)

☐ I consent to transfusion of blood or blood products

☐ I do not consent to transfusion of blood or blood products

☐ I consent to moderate sedation

X-RAY:

X-rays will be used to guide your procedure. There is a slight chance that because you have had this radiation you may get minor temporary skin burns or hair loss. Other complications that may occur, but are extremely rare, include severe skin burns and permanent hair loss where the x-rays enter the body. There is a very small increased chance of cancer with any x-rays.

PATIENT STATEMENT:

I have read this consent form and/or it has been explained to me. I fully understand and am satisfied with the answers to my questions as explained by my doctor.

Signature: ______________________________ Date: __________ Time: __________

(Patient or person with authority to sign consent for patient)

PHYSICIAN'S STATEMENT:

The patient (or authorized representative) and I have discussed the procedure, risks, benefits, side effects, and alternatives. To the best of my knowledge, the patient (or authorized representative) understands the procedure and consents to it.

Signature: ______________________________ Date: __________ Time: __________