



AUTHPR

I hereby authorize Dr. _____ and/or such assistants selected by him/her to perform _____ arteriogram. This procedure involves puncturing an arm or leg artery with a needle and sliding a catheter into the artery, injecting X-Ray dye and taking pictures. I further authorize the performance of interventions necessary to correct any problem that may be identified. These interventions may include any of the following:

- 1) Angioplasty, which is performed by inflating a small balloon to open blocked or narrowed vessels.
- 2) Stent placement, to keep vessels open.
- 3) Thrombolysis, which involves the injection of a clot-dissolving medication into a clotted vessel.
- 4) Clot maceration, which involves using a device to break up a clot.
- 5) Embolization, which involves the injection of a material or device to stop blood flow through a vessel.

I also authorize the use of moderate sedation, which involves administration of medication to relax me during the procedure.

I acknowledge the risks of the above procedure which include: infection; blood vessel damage; bleeding which could require blood transfusion and / or emergency surgery; embolization of clot which can threaten life or limb; kidney damage; and allergic or adverse reaction to any of the agents used.

I also acknowledge that the doctor cannot guarantee a good outcome for this or any other procedure. However, I understand that the doctor feels this procedure is the best treatment for my medical condition and that he/she feels the potential benefits outweigh the risks of this procedure.

I have read the above content and all my questions regarding the procedure, benefits, risks and possible alternatives have been answered to my satisfaction.

_____	/	/
Patient	Date	Time
_____	/	/
Witness	Date	Time
_____	/	/
Relative	Date	Time
_____	/	/
Physician	Date	Time



ARTERIOGRAM CONSENT FORM

▼ Addressograph / Patient Label ▼