

AUTHORIZATION FOR CARDIAC CATHETERIZATION, INTERVENTION



DATE: _____ TIME: _____

I authorize and direct Dr. _____ and the associates, assistants, or consultants of his choice, to perform the following operation and/or procedure: Heart catheterization, balloon angioplasty, stent, rotator, directional coronary atherectomy, intra-aortic balloon counterpulsation, temporary pacemaker, angiojet, percutaneous bypass support, pulmonary artery monitoring, and/or intravascular ultrasound, or

And such additional therapeutic operations or procedures as his or their judgment may dictate on the basis of findings during the course of the procedure.

Risks may include, but are not limited to, infection, bleeding, damage to nerve(s), artery(s), vein(s), lung, heart, kidney, stroke, blood clots, contrast (dye) allergy, loss of limb, need for emergency heart surgery, and/or death.

My physician has discussed with and explained to me the nature and purpose of the operation and/or procedure, the possibility that complications may arise or develop, significant risks, which may be involved, possible alternative methods, and the risk of refusing treatment. I am aware that other risks or complications may occur. I have the opportunity to ask questions of my physician, and my physician has answered all of my questions to my satisfaction.

I understand that no warranty or guarantee had been made as to the result or cure. I authorize and direct the above named physician and his associates, assistants, and consultants to provide such additional services during the procedure and in the immediate post-operative period as they deem reasonable and necessary including but not limited to, the administration of maintenance of and recovery from anesthesia or IV moderate sedation, the performance of services involving pathology and radiology, and the use of resuscitative measures. Any tissues or parts surgically removed may be retained or disposed of by the hospital in accordance with its usual practice. I consent to the use of my hospital record for the purpose of review / presentation for medical education. I have read and understand this authorization.

Patient's Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

If patient is a minor or unable to sign, complete the following:

Patient is a minor Patient is unable to sign because: _____

Parent or guardian: _____ Relationship: _____



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