



**EMBOLIZATION CONSENT FORM**

I hereby authorize Dr. \_\_\_\_\_ and/or such assistants selected by him/her to perform Embolization therapy of (area) \_\_\_\_\_ on (pt Name) \_\_\_\_\_. This procedure involves puncturing an arm or leg artery with a needle through the skin and into a artery leading to the specific area to be treated. The appropriate artery will be identified and then the embolization material best suited for the procedure will be injected to occlude the vessel.

I authorize the use of local anesthesia as well as conscious sedation to decrease discomfort during the procedure.

I acknowledge the risks of the above procedure, which include:

- 1) Pain
- 2) Infection, which could include abscess formation
- 3) Allergic reaction to medications, contrast or embolization materials
- 4) Migration of the embolization material could result in a damage to major organs including liver, uterus, kidneys, lungs, intestines, and brain.
- 5) Kidney damage due to contrast material.

I acknowledge that there is no guarantee of a good outcome from this or any other procedure. However, I understand that the doctor feels the potential benefits outweigh the risks of this procedure.

I acknowledge that I have received explanation of any possible alternative treatments.

All of my questions regarding the procedure, the risks, the potential complications, and the alternatives have been answered to my satisfaction.

	/		/	
Patient's Signature		Date		Time
	/		/	
Witness		Date		Time
	/		/	
Relative		Date		Time
	/		/	
Physician		Date		Time



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CONSENT FORM**

▼ Addressograph / Patient Label ▼