

FISTULOGRAM/GRAFTOGRAM CONSENT FORM

I hereby authorize Dr. _____ and/or such assistants selected by him/her to perform a fistulogram/graftogram. This procedure involves puncturing the dialysis access with a needle, sliding a catheter in, 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 the 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.
6. Insertion of a temporary or tunneled catheter for the purpose of dialysis

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 / 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 the 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