



AUTHPR

I hereby authorize Dr. _____ and/or such assistants selected by him/her to perform abdominal aortic and mesenteric/celiac arteriogram. This procedure involves puncturing an arm or leg artery with a needle and sliding a catheter into the large artery of the abdomen, injecting X-Ray dye and taking pictures of the arteries in the abdomen. 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) Embolization, which involves the injection of a material or device to stop blood flow through a vessel.
- 5) Infusion of a vasopressive drug in an effort to control bleeding.

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: blood vessel damage; internal bleeding which could be severe enough to require surgery, kidney damage; allergic or adverse reaction to any of the agents used; infection; infarction of intestine or other major organs.

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.

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|-----------|------|------|
| Patient | / | / |
| | Date | Time |
| Witness | / | / |
| | Date | Time |
| Relative | / | / |
| | Date | Time |
| Physician | / | / |
| | Date | Time |



MESENTERIC ARTERIOGRAM CONSENT FORM