



AUTHPR

I hereby authorize Dr. _____ and/or such assistants selected by him/her to perform Carotid and Cerebral Arteriography on me. I understand this involves puncturing an arm or leg artery with a needle and sliding a small catheter into the arteries in the neck and injecting X-Ray dye to evaluate the arteries and vessels of the neck and brain.

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 or plaque which can result in a stroke; 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 |



▼ Addressograph / Patient Label ▼

CAROTID/CEREBRAL ARTERIOGRAM CONSENT FORM