

**DOWNSTATE MEDICAL CENTER  
STATE UNIVERISTY HOSPITAL**

**CONSENT FOR CARDIAC CATHERIZATION  
ANGIOGRAPHY AND  
SELECTIVE CORONARY ANGIOGRAPHY**

NAME

MR #

N.S.

SERVICE/DOCTOR

AFFIX LABEL OR COMPLETE

Date \_\_\_\_\_

Time \_\_\_\_\_ AM  
PM

Patient \_\_\_\_\_  
(Last Name) (First) (Middle Initial)

Age at Last Birthday \_\_\_\_\_ (Patients under 18 years of age to complete Supplement For  
Persons under Age 18 Intending to Consent For Themselves)

1. I hereby give authorization and consent for the performance upon \_\_\_\_\_  
(State "myself" or name of Patient)  
of Cardiac Catheterization, Angiography, and Selective Coronary Angiography, to be performed by Dr. \_\_\_\_\_  
and whomever he/she may designate as his/her assistants.  
(Name of Physician)

2. It has been stated to me that during cardiac catheterization and selective angiography plastic tubes will be inserted into my veins and arteries and advanced into my heart. Dye will then be injected through the tubes and enter my body in order to act as a material to show up on X-rays. It has been further explained to me that this entails certain risks which include death (in rare instances), cardiac arrest, heart attack, stroke, disturbances of cardiac rhythm, blood clots in various organs of the body, injury to the arterial or vein walls, bleeding, injury to nerves or limbs, loss of pulsation in limbs due to arterial obstruction, loss of part or all of a limb, persistent pain in the limbs, paralysis and allergic reaction to dye.

3. I further consent to the administration of anesthesia and acknowledge that the probable anesthesia has been identified to me. The reasonable risks, complications and alternative anesthetics or anesthetic procedures have been explained to me. There are no anesthetics that I have reason to believe are harmful to me except \_\_\_\_\_, I acknowledge that no guarantee has been given to  
(Indicate exception to none)  
me about the effects of the anesthetic used. I further consent to the supervision of my anesthesia care by a qualified anesthesiologist.

4. I have been advised of the serious nature of the treatment(s) and have been advised that if I desire a further and more detailed explanation of the foregoing, as well as information about more remote risks or complications of the above listed operation/procedure, such explanation will be given to me.

5. I do not desire any further or additional explanation.

6. I also consent to the performance of procedures in addition to or different from those described above, arising from conditions which are presently unforeseen or believed unlikely, if the above-named doctor or those under his/her direction, in their best professional judgment, consider it necessary or advisable during the course of the operation or procedure. Under no circumstances, however, do I consent to

\_\_\_\_\_  
(State nature and extent of treatment(s) for which consent is not given)

7. I acknowledge that I have received no guarantees about the benefits or results of this treatment.

8. In the interest of medical education, I consent to observers being admitted during this operation, treatment or procedure to the operating room.

9. I consent to the disposal by hospital authorities of any tissues or body parts which may be removed.

10. I consent to the administration of such drugs, infusions, transfusions of blood or blood components, or any other treatment deemed necessary or desirable in the judgment of the above-named doctor or those acting under his/her direction.

11. I acknowledge that I have read this entire document and that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

Date \_\_\_\_\_  
Signature of patient

If consenting party is other than patient:

\_\_\_\_\_  
(State Relationship to Patient)

Witnesses:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

### PHYSICIAN STATEMENT

I have discussed the nature and purpose of the above operation. Treatment(s) or procedure, and the associated risks, consequences and available alternatives, with the person signing above, and I am satisfied that he/she understands them.

\_\_\_\_\_  
Signature of Physician Providing Explanation M.D.