BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Cerebral Angiography

This information is given to you so that you can make an informed decision about having a **cerebral angiography.**

Reason and Purpose of the Procedure
Cerebral angiography is a way to look at the blood supply of the brain. A hollow tube or catheter is placed in an artery. Dye is injected into the catheter. X-ray images are taken to show how blood moves to and from your brain. Most blood supply problems of the brain can be found by this method. You will be given medicine during this procedure to make you sleepy.

Benefits of this Procedure
You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Identify or confirm a problem with blood vessels in the brain.
- Helps the doctor decide your treatment options.

Risks of a Procedure
No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General Risks of a Procedure

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Clots may form in the legs, with pain and swelling**. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- A **strain** on the heart or a stroke.
- **Bleeding.** If excessive you may need a blood transfusion.
- **Reaction to the anesthetic**. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you

Risks of this Procedure

- **Allergic reaction to contrast dye** -Tell the doctor if you are allergic to shellfish or iodine.
- **Bleeding at the puncture site** - Bleeding can occur at the catheter insertion site and cause a hematoma (blood under the skin with swelling.)
- **Contrast Induced Renal Failure or CIRF** - There is a risk of kidney failure caused by the contrast dye used during the procedure. This risk is higher for people with poor kidney function, kidney transplant, taking ACE inhibitors, NSAIDS (non-steroidal anti-inflammatory drugs), glucophage and people over the age of 70. This may require you to stay in the hospital longer.
- **Infection** - Infection may occur in the wound, either near the surface or deep within the tissues.
- **Stroke** - There is a risk of stroke caused by the catheter. While being navigated (steered) through the carotid arteries the catheter could break off a plaque that could block a smaller blood vessel in the brain and lead to stroke.
- **Vessel dissection** - Damage to an artery or artery wall from the catheter. Rarely, this damage could lead to loss of function of the affected limb (arm or leg).

Risks Associated with Smoking
Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity
Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Diabetes or Immune System Compromise
The risk of infection, slow wound healing and slow bone healing (fusion) are increased in:

- Diabetes
- Chemotherapy or radiation therapy
- AIDS
- Steroid use

Risks Specific to You

_____
_____
_____
_____

Alternative Treatments
Other choices:

- Treat the condition with medication (if appropriate)
- Take pain medication
- Do nothing. You may decide not to have the procedure.

If you chose not to have this Procedure

- Your doctor may not be able to treat your condition.
- You could have a stroke.
- Your condition could cause death if not treated. Your doctor will discuss this with you.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way**.**
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Implants or explants:
I agree to release my social security number, my name and address, and my date of birth to the company that makes a medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me.

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By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the Doctor or Nurse. My questions have been answered.
- I want to have this procedure: **Cerebral Angiography**
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature_____Date:_____Time:_____
Relationship: □Patient □Closest relative (relationship)_____ □Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date_____Time_____
Interpreter (if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

OR
____ Patient elects not to proceed: _____ Date:_____ Time:_____
(patient signature)
Validated/Witness:_____ Date:_____Time:_____