



Affix Patient Label

Patient Name:

Date of Birth:

### **Informed Consent: Atrial Fibrillation Catheter Ablation with Trans-esophageal Echocardiogram (TEE)**

This information is given to you so that you can make an informed decision about having an **Atrial Fibrillation Catheter Ablation with Trans-esophageal Echocardiogram (TEE)**. This procedure is most often done with moderate sedation or anesthesia.

#### **Reason and Purpose of this Procedure:**

In this procedure, the heart's electrical system is checked. If problems are found, your doctor may fix them.

A catheter(s) is placed into blood vessel(s) of the leg, neck, throat or arm. A catheter is a long, thin, flexible tube. The catheters slide through your blood vessels to your heart. X-rays are used to position the catheter.

The heart's electrical signals are measured. The heart may be stimulated to make certain heart rhythms. You may have electrical pathways in your heart that are not normal. These pathways can cause rhythm problems. The problems can be fixed by using radio waves or freezing them.

This procedure also uses Trans-esophageal echocardiography (TEE) to take a picture of your heart using an ultrasound test. A camera-like tube, about the thickness of a finger, is placed into your mouth and into your esophagus (the tube that connects the mouth to the stomach). Placing the camera-like tube into the esophagus provides pictures that are more detailed. The camera-like tube is able to get a better picture because it is closer to the heart. The view is not blocked by other parts of the body such as ribs and lungs.

#### **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.

- Diagnose and possibly treat abnormal heart rhythms. Help decide the best way to treat the abnormal heart rhythm.

#### **Risks of this 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.

- Bruising and/or swelling at the puncture site. This may need surgery.
- Blood loss. Fluids or a blood transfusion may be needed.
- Damage or a tear in the heart. This may need surgery.
- Exposure to radiation. Medicine and monitoring may be needed.
- Abnormal heart rhythms. Fluids, medicines or permanent pacing may be needed.
- Infection. Antibiotics or other treatment may be needed.
- Reactions to medicines or other substances used during the procedure.
- Stroke.
- The procedure may not cure or relieve your condition.
- Additional tests or treatment may be needed.
- Heart attack.
- Damage to blood vessels. Surgery may be needed.
- Nerve damage. Medicines may be needed.
- Constant pain. Medicines may be needed.
- Esophageal damage. This may require surgery.
- Damage to teeth and gums or esophagus.

- Pulmonary vein stenosis. This may require a stent.
- Death may occur.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

**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 Specific to You:**

---

---

---

**Alternative Treatments:**

Other choices:

- Medicine and/or observation by your physician.
- Do nothing. You can decide not to have the procedure.

**If you Choose not to have this Treatment:**

- Your symptoms or heart rhythm may worsen.

**Information on Moderate Sedation:**

You will be given medicine in an IV to relax you. This medicine will also make you more comfortable. This is called “moderate sedation”. You will feel sleepy. You may even sleep through parts of your procedure. We will monitor your heart rate and your blood pressure. We will also monitor your oxygen level.

If your heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may be unable to reverse the sedation. We may need to support your breathing.

Even if you have a NO CODE status:

- You may need intubation to support your breathing.
- You may need medications to support your blood pressure.

We will re-evaluate your medical treatment plan and your NO CODE status when sedation has cleared your body.

**Benefits of Moderate Sedation:**

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.

- Less pain during the procedure.
- Less anxiety or worry.

- Decreasing your memory of the procedure.

**Risks of Moderate Sedation:**

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. The list includes:

- Decreased breathing during the procedure and dropping oxygen levels. To help you breathe, a tube may be placed into the mouth or nose and into the trachea to help you breathe.
- Allergic reactions: nausea & vomiting, swelling, rash.
- Vomit material getting into the lungs.
- A drop in blood pressure. This needs fluids or medicine to increase blood pressure.
- Heart rhythm changes that may require medicines to treat.
- Not enough sedation or analgesia resulting in pain or discomfort.

Your physical and mental ability may not be back to normal right away. You should not drive, or make important decisions for at least 24 hours after the procedure.

**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 taken during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Affix Patient Label	
Patient Name: _____	Date of Birth: _____

**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. My questions have been answered.
- I want to have this procedure: **Atrial Fibrillation Catheter Ablation with Trans-esophageal Echocardiogram (TEE)** \_\_\_\_\_
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. 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 procedure. If so, please obtain consent for blood/products.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Relationship:**  Patient       Closest relative (relationship) \_\_\_\_\_       Guardian/POA Healthcare

**Interpreter's Statement:** I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**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:**  
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: \_\_\_\_\_