



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent: Angiogram with Possible Vascular Embolization

This information is given to you so that you can make an informed decision about having an **angiogram with Possible Vascular Embolization**. This procedure is most often done with moderate sedation or anesthesia.

Reason and Purpose of this Procedure:

- There is a high possibility that you have a bleed from a blood vessel that needs to be stopped.
- You have been diagnosed with a fibroid/tumor that would benefit from blocking blood vessels to stop blood flow to the area.
- You are at risk of bleeding which may be reduced by blocking blood vessels.

An **angiogram** uses x-rays and a special dye (contrast) to take pictures of your blood vessels. This lets your doctor see the blood flow in the affected part of your body. Local anesthetic is injected at the insertion site, typically in the groin or arm, before a small tube or catheter is inserted into an artery or vein. After this the dye is injected pictures are taken using an x-ray machine. This procedure can help the doctor diagnose the problem and identify what vessels need to have an embolization.

An **embolization** occurs when the catheter tip is placed into the target blood vessel. A material known as an embolic agent is injected to stop the blood flow to that area.

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.

- Locate a bleed site.
- Treat areas by blocking the blood supply.
- May prolong life and relieve symptoms.

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.
- **Movement of embolic agent to non-target sites.** This can cause a decreased or stopped blood flow to an unintended area. This may require surgery or another procedure.
- **Blood loss.** You may need fluids or possibly a blood transfusion.
- **Infection.** You may need medicines or other treatment.
- **Stroke.** This may lead to more testing, surgery, and treatment for stroke.
- **Allergic reaction to the contrast or dye.** Fluids and /or medications may be needed.
- **Loss of kidney function.** This may require fluids, medications, or other treatments.
- **The procedure may not cure or relieve your condition.**
- **Injury to a blood vessel and/or internal bleeding.** You may need surgery. This is rare.

Known Potential Side Effects of the Procedure:

Post-embolization syndrome: This may include:

- Low grade fever.
- Pain.
- Flu-like symptoms.
- Fatigue.
- Nausea and vomiting.
- Decreased appetite.

Potential Radiation Risks:

- **Any exposure to radiation may cause a slightly higher risk for cancer later in life.** This risk is low.
- **Skin rashes.** Skin rashes may lead to breakdown of skin and possibly severe sores. This is rare.
- **Hair loss.** This does not happen to everyone. This can be temporary or permanent.
- **It is possible we may have to use higher doses of radiation.** If we do, we will tell you.
- **If you see changes with your skin, you should report them to your doctor.**

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:

- Observation.
- Surgery.
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- Your symptoms may get worse.
- Your condition may get worse.

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.

Students, technical salespeople, 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.

Medical Implants/Explants:

I agree to release my social security number, my name and address, and my date of birth to the company that makes the 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. My questions have been answered.
 - I want to have this procedure: **Angiogram with Possible Vascular Embolization** _____
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- 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

Reason patient is unable to sign: _____

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: _____

Telephone Consent ONLY: *(One witness signature MUST be from a registered nurse (RN) or provider)*
 1st Witness Signature: _____ 2nd Witness Signature: _____ 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: _____