

**CONSENT FOR CARDIAC (HEART) CATHETERIZATION
AND/OR CORONARY INTERVENTION
(If Coronary Intervention - With Heart Surgery Available)**

(Affix Patient Label)

**PATIENT CONSENT FOR HEART CATHETERIZATION / CORONARY ANGIOPLASTY / INTRACORONARY STENT PLACEMENT
AND ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION.**
(This form is designed to comply with the requirements of the Louisiana Medical Disclosure Panel)

INFORMATION ABOUT THIS DOCUMENT - READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider Heart Catheterization/Coronary Angioplasty/Interventional Stent Placement/Rotablator - Louisiana law requires us to tell you:

(1) the nature of your condition, (2) the general nature of the procedure, (3) the risks of the proposed procedure, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable diagnostic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand and we will explain it.

1. Patient Name: _____

2. Procedure: Cardiac Catheterization / Coronary Angioplasty / Interventional Stent Placement

(a) Description, nature of the procedure: Insertion of tubes into the blood vessels of the leg or arm and pass them to the heart with x-ray guidance, to inject dye, measure pressures, pass small wires and inflate balloon tipped tubes to open up blocked arteries to implant a wire mesh (stent) into a blocked artery to help keep it open, insert rotating diamond bedded burr to open artery, insert special ultrasound wire to visualize inside of artery. To administer high potency clot dissolving medications to assist with keeping the vessel open.

(b) Purpose: Evaluate the arteries to the heart and/or perform angioplasty and/or stent placement if indicated.

3. Patient Condition: Patient's diagnosis or description of the nature of the condition for which the procedure is described in item number two is indicated and recommended.

4. Material Risks of Procedure:

(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego coronary angiography/angioplasty/stent. Please ask your physician if you would like additional information regarding the nature of consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

Very Uncommon

Brain damage
Quadriplegia (Paralysis of arms and legs)
Paraplegia (Paralysis of both legs)
Loss of Organ
Blood clots in lungs
Loss of Arm or Leg
Loss of function of organ
Loss of function of arm or leg
Disfiguring scars
Cardiac perforation
Stroke or kidney failure
Death
Artery Surgery in leg or arm to fix hole

Uncommon

Pseudoaneurysm
Infection
Arrhythmia requiring electrical shock (defibrillation) or temporary pacemaker
Heart attack
Dye contrast reaction
Arteriovenous fistula
Bleeding requiring blood product transfusion(s)
Emergency coronary bypass surgery
Emergency angioplasty, and/or stent placement

Common

Hematoma
Bruising
Bleeding

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are: _____

(c) Risks generally associated with transfusion of blood and blood components: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (acquired immune deficiency syndrome), and other infections.

5. Reasonable alternatives and the risks associated with such alternatives are: _____

6. ACKNOWLEDGEMENT, AUTHORIZATION AND CONSENT

(a) NO GUARANTEES: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternative procedures or as to the prospects of success, are made in the best professional judgement of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information in this document.

(c) PARTICULAR CONCERNS: I have had an opportunity to disclose to and discuss with the physician providing such information those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) QUESTIONS: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) AUTHORIZED PHYSICIAN/GROUP: The physician(s) authorized to administer or perform the medical treatment, surgical procedure, or other therapy described in item two.

(f) PHYSICIAN CERTIFICATION: I hereby certify that I have provided and explained the information set forth herein, and answered all questions of the patient or the patient's representative concerning the medical treatment or surgical procedure to the best of my knowledge and ability.

Signature of Physician	Date	Time
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(circle physician performing)

CONSENT: I hereby authorize and direct Dr. V. Gonzalez, Dr. Greg Sampognaro, Dr. Stephen Ramee, Dr. Chris White together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item two of this consent form, including any additional procedures as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item three of the consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Witness	Date	Time
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Patient or Person Authorized to Consent	Date	Time
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Relationship _____

If consent was signed by someone other than the patient, state the reason: _____
