UNIVERSITY OF VIRGINIA HEALTH SYSTEM

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

0100000

CONSENT FOR RIGHT HEART CATHETERIZATION AND EXERCISE STRESS TEST

A. CONSENT FOR PROCEDURE

1. I authorize _____ to perform the following procedure(s): **RIGHT HEART CATHETERIZATION AND EXERCISE STRESS TEST.**

I understand that I may need other urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners may be chosen to do or help with procedures. I UNDERSTAND THAT PHYSICIANS IN TRAINING, INCLUDING RESIDENTS (DOCTORS WHO HAVE FINISHED MEDICAL SCHOOL AND ARE GETTING MORE TRAINING), CARDIOLOGY FELLOWS, AND REGISTERED NURSES MAY PERFORM PORTIONS OF THE PROCEDURES DESCRIBED BELOW UNDER THE PARTICIPATORY SUPERVISION OF MY ATTENDING PHYSICIAN. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges.

2. I understand my diagnosis/condition to be: _____

3. I have been told about what to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed.

4. I have been told about and understand the risks and benefits of the procedure(s) listed above. These risks, which can be serious, include: **BLEEDING, INFECTION, HEMATOMA, VESSEL INJURY, RUPTURE OF A PULMONARY BLOOD VESSEL, LUNG COLLAPSE, VOCAL CORD PARALYSIS, SEIZURES, CARDIAC TAMPONADE, TEMPORARY NUMBNESS OR TINGLING OF THE RIGHT ARM AND FACE, MUSCULOSKELETAL TRAUMA, FATIGUE, DIZZINESS OR FAINTING, CHEST DISCOMFORT OR HEART POUNDING, SHORTNESS OF BREATH, SLOW OR RAPID HEART RHYTHMS, ABNORMAL HEART RHYTHMS, LOW OR HIGH BLOOD PRESSURE, CONGESTIVE HEART FAILURE, STROKE, HEART ATTACK, SHOCK, CARDIAC ARREST AND DEATH.**

5. I understand the alternatives to the proposed procedures to be: **NO TEST, MEDICAL MANAGEMENT WITHOUT BENEFIT OF THE INFORMATION GAINED FROM CATHETERIZATION AND STRESS TEST EXERCISE.**

I understand the related risks of proposed alternative treatments.

6. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.

7. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.

(CONTINUED ON NEXT PAGE)

UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

B. CONSENT FOR ANESTHESIA OR SEDATION

1. When local anesthesia and/or sedation is used by the physician on page one, Section A1:

I consent to the administration of such ***local anesthetics*** as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

I consent to the administration of ***sedative medications*** by or under the direction of the physician named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

---

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the **Department of Anesthesiology:**

I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic ("being put to sleep") and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative
☐ 2. Guardian ☐ 5. Parent ☐ 8. Other* _____
☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

*** Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.**

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	DATE	TIME

SIGNATURE OF WITNESS (OPTIONAL) **REQUIRED FOR TELEPHONE CONSENTS**	PRINTED NAME	DATE	TIME

E. INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	DATE	TIME