**OUT PATIENT PROCEDURE INSTRUCTIONS**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOU ARE SCHEDULED FOR AN OUTPATIENT PROCEDURE. PLEASE REPORT TO OUTPATIENT REGISTRATION AT:**

St. Francis Hospital / Piedmont Columbus Regional ON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITAL DATE TIME

You are scheduled for a Transesophageal Echocardiogram **(TEE).** Please make sure that you have someone to drive you home once you are released from the hospital. NO driving for 24 hours after the procedure. While we do our best to remain on schedule, we do not know how long the case before yours will take. There are also emergencies that can delay the schedule.

DO NOT EAT OR DRINK ANYTHNG AFTER MIDNIGHT, the night prior to your procedure.

Please TAKE all the other medications the morning of the procedure.

(You may have a few sips of water.)

If you take Diabetic medication, **DO NOT TAKE** the night before your procedure or the morning of your procedure. **PLEASE NOTE:** IF YOU ARE PATIENT OF AN ENDOCRINOLOGIST, PLEASE CONTACT THEIR OFFICE FOR INSTRUCTIONS CONCERNING YOUR DIABETIC MEDICATIONS.

PLEASE BRING ALL YOUR MEDICATIONS WITH YOU TO YOUR PROCEDURE.

(NOTE: We do our best obtain referrals and required pre-certification: however, it is ultimately the PATIENTS RESPONSIBILTY to verify benefits and coverage and to inform our staff of any insurance changes.)

**If you have any questions, please contact our office at 706-243-4502.**

**INFORMED CONSENT: DO NOT SIGN THE FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND IT.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge and understand that the following procedure(s) to be performed on me have been explained to me:

\_\_\_\_\_ LEFT HEART CATHERIZATION (LHC) \_\_\_\_\_ STENT PLACEMENT

\_\_\_\_\_ RIGHT HEART CATHERIZATION (RHC) \_\_\_\_\_ CARDIOVERSION

\_\_\_\_\_ CORONARY ANGIOPLASTY (PTCA) \_\_\_\_\_ TEE

\_\_\_\_\_ BYPASS GRAFT ANGIOGRAGH **\_\_\_\_\_** OTHER

The following have been explained to me in layman’s terms:

1. My Medical Diagnosis
2. \_\_\_\_ Coronary Artery Disease (CAD)
3. \_\_\_\_ Worsening symptoms consistent with Ischemic Heart Disease
4. \_\_\_\_ Cardiomyopathy
5. \_\_\_\_ Valvular Heart Disease
6. \_\_\_\_ Atrial Fibrillation
7. \_\_\_\_ Other
8. Material Risks of Procedure: The material risks associated with the above procedure(s) were discussed and include, but are not limited to:
9. Death- There is a 0.1% risk of death from heart catherization.
10. Myocardial Infarction- There is a 0.05% risk of heart attack from heart catherization.
11. Stroke- Stroke occurs in 0.05% of heart catherization.
12. Coronary Artery Dissection.
13. Coronary Artery Spasm.
14. Renal Failure
15. Emergency Open Heart Bypass Surgery
16. Irregular Heart Rhythms requiring electrical shock, pacemaker, and/or Heart Rate requiring medical treatment
17. Heart Failure
18. Vagal Reactions- can cause significant lowering of blood pressure and/or Heart Rate requiring medical treatment
19. Vascular Injury- Injury most often occurs, can require surgical repair
20. Bleeding – If bleeding occurs, it is most often at site of insertion of catheter
21. Infection
22. Neuropathy- Risk of damage to nerve around catheter insertion site
23. Allergy – Allergic reactions to contrast dye can range from hives to shock (anaphylaxis)
24. Available alternatives to the above procedures that were discussed include:
25. Empiric Medical Therapy
26. Treadmill or Pharmacologic Stress Testing with or without Nuclear Imaging

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure or treatment.

I understand during the course of the procedure or treatment described to me above that it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time diagnostic studies, test, anesthesia, x-rays examinations, and other procedures performed in the course of my treatment. I consent to and authorize the persons described herein to perform such additional procedures and treatments as they deem necessary or appropriate.

Depending on patient’s diagnosis and the procedure and treatment to be performed, it may be necessary or appropriate for tissues and specimens to be removed from the patient’s body. I consent to the removal, testing, retention for scientific or teaching purposes, and disposal of such specimens with in discretion of Dr. Shane B. Darrah, Dr. Akram W. Ibrahim or Dr. Hunter C Champion, Hospital, or other Hospital Healthcare Provider.

Additional materials used in the informed consent process include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby voluntarily request and consent to the performance of the procedure(s) and or treatment(s) described or referred to herein by Shane B. Darrah, M.D. and any other physicians or medical personnel who may be involved in the course of my treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON GIVING CONSENT (RELATIONSHIP TO PATIENT IF PERSON GIVING CONSENT IS NOT PATIENT AND REASON WHY UNABLE TO SIGN)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_