Hospital Log	0
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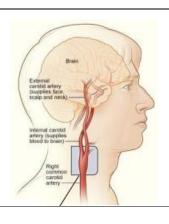
Informed Consent for Carotid Stenting

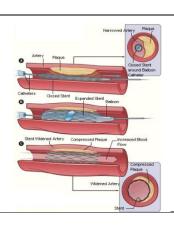
Name:	Age (in years):	Gender: ☐ M ☐ F ☐ Other					
UHID No./Registration No.:							
Interpreter Service: ☐ Yes ☐ No	Consultant's Name:						
Medical Condition							
The doctor has explained that I/my child/myhave the following medical condition:							
and I/my child/myhave been explained and advised to undergo the following treatment/procedure:							
I authorise Dr		and					
his/her associates to perform the above treatment/ procedure.							
The doctor should document the site and/or side where relevant to the procedure:							

Introduction

A carotid stenting is a procedure in which a small metal mesh tube is placed into the narrowed part of the carotid artery. It is used to stretch and open the inside of the artery. This procedure will require an injection of local anaesthetic and the use of a sedation or general anaesthetic.

The doctor will insert the stent by placing a needle and thin plastic tube (catheter) into the artery in your groin. The stent will stay in situ for life.





Consent for Blood Transfusion

Please see Blood Transfusion Consent Form. This will give you information about the type of the blood products, benefits and risks of blood transfusion. If you have any concern(s), please discuss with your doctor.

Consent for Anaesthesia

Please see Anaesthesia Consent Form. This will give you information about the type of the anaesthesia, its benefits and general risks. If you have any concern(s), please discuss with your anaesthetist(s).

Intended Benefits (To be documented by doctor)	Risks and Complications (To be documented by docto	Patient Specific Risks (To be documented by doctor)	
	Risks Stroke	Sedation related risks: Faintness or dizziness	1)
	InfectionNerve damage	Fall in blood pressureNausea	2)
	The stent may suddenly closeDamage to surrounding structures such as	VomitingWeakness	3)
	 blood vessels, organs and muscles A blood clot or excessive bleeding from the puncture site Minor pain, bruising and/or infection from the IV cannula Pain or discomfort at the puncture site Low blood pressure and slow heart rate Failure of local anaesthesia 	 Heart and lung problems such as heart attack or vomit in the lungs causing pneumonia. Stroke resulting in brain damage Others, if any specify: 	4)
	DeathOthers, if any specify:	Contrast related risks: Giving the contrast to people with weakened kidneys (renal impairment), can cause further kidney damage, leading to acute renal failure.	
Likelihood of the Su	ccess Rate of Procedure (To be documented by doctor)	Alternatives (To be documented by doctor) Surgical endarterectomy	<u>'</u>

Hospital Logo					Patient Ide	ntification Label	
	Informed	d Consent for C	arotid Ste	nting			
			■ Others,	if any specify:			
Specific Notes Related to Procedure (Strike out if not required)			Precise Action Points Understood by the Patient/Substitute Decision Maker (To be documented by patient/substitute decision maker in his/her language)				
Patient's Authorisa			L				
	explained my/the patient's me intended benefits/risks know			-		=	
specific to me/	the patient and their likely ou	itcomes.	•	·	_		
	explained other relevant/alte isks of not having the procedu	-				ctor has also	
I was able to as	k questions and raise concerr	ns with the doctor ab	out the proce	dure and its be	•	//patient's treatment	
	eries and concerns have beer at the treatment/procedure		-		r which a separate o	consent shall be	
obtained).	·	•	•				
• The doctor has explained the requirement for anaesthesia for this procedure and I understand the risks associated with anaesthesia, including the risks specific to me (for which a separate consent shall be taken).							
I understand th	at if organs or tissues are ren	noved during the surg	gery that these	e may be retair	ned for prescribed t	tests and shall be	
•	nsitively by the hospital as per explained to me, that during			operation/pro	ocedure, unforesee	n conditions may be	
revealed or end	countered which may necessi	tate urgent surgical o	r other proced	dures in additio	on to or different fr	om those	
· ·	In such exigency, I further redical or other procedures as he	•			-		
such condition	there will be no requirement	of any additional con	sent from me	or my family r	members/attendan	ts.	
	o guarantee of whatsoever na at I have the right to refuse to	_			•		
writing and ack	nowledged by the hospital ar	nd I shall be solely res	ponsible for t	he outcome of	such refusal.		
• I consent to if any photographing or television of operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes. However, suitable precautions shall be taken by the hospital that my identity is						-	
not revealed ar	nywhere Yes Do		·				
For purposes or	f advancing medical education	n, I consent to the ad	mittance of ol	bservers to the	e operating room.	□ Yes □ No	
Patient Name:			Signature:			Date and Time:	
Cultatituta Daninian	N. A. J. c. a. N. c. c.	Dolotio nobin	_	iant ia mahla	Cimatura	Data and Times	
Substitute Decision	Maker Name:	Relationship:		ient is unable ent because):	Signature:	Date and Time:	
			_				
Witness Name:		Relationship:	<u> </u>		Signature:	Date and Time:	
Interpreter Name: Translation given in:		Signature:	Date and Time:				
Declaration by the Doctor							
I have explained to the patient / authorised representatives the medical condition, need for the procedure, its alternatives and benefits/risks, likely consequences if those risks occur and the significant risks and problems specific to this patient including the risks of not							
undergoing the prod	cedure. I have given the patie	nt/ authorised repres	entatives an o	opportunity to	ask questions abou	_	
matters and raise any other concerns. I have answered all their queries to the best of my knowl Name and Signature of the Doctor with Reg No: Date and T				Date and Tim			