

## Informed Consent for Cerebral Angiography

Name:	Age (in years):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
UHID No./Registration No.:		
Interpreter Service: <input type="checkbox"/> Yes <input type="checkbox"/> No	Consultant's Name:	

**Medical Condition**  
 The doctor has explained that I/my child/my .....have the following medical condition:  
 .....  
 and I/my child/my.....have 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**  
 Cerebral angiography is an X-ray procedure used to visualise the blood vessels of the neck, head and brain (cerebral = head, angio = blood vessel, graphy = picture). The doctor will inject general anaesthesia to prevent pain. And then insert a small catheter into an artery through a 2mm incision (cut). The doctor will inject a dye into the catheter. As the dye travels through the blood vessels to your brain, the doctor will rapidly take X-rays (several per second). During this procedure, you may feel a slight heat, uncomfortable feeling in your head that will last for 5 to 20 seconds. The doctor will remove the catheter and apply pressure to the area for about ten minutes so that the artery does not bleed.

**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 doctor)	Patient Specific Risks (To be documented by doctor)
<ul style="list-style-type: none"> <li>▪ It presents a very detailed, clear and accurate picture of blood vessels in the brain.</li> <li>▪ The results are more accurate than those produced by carotid doppler ultrasound or other non-invasive imaging of the blood vessels.</li> <li>▪ The use of a catheter makes it possible to combine diagnosis and treatment in a single procedure.</li> <li>▪ Others, if any specify:</li> </ul>	<p><b>Procedure related risks:</b></p> <ul style="list-style-type: none"> <li>▪ The puncture in the artery may not seal across leading to a blood leak. It may form a lump and a large bruise.</li> <li>▪ The circulation to the leg may be interfered with due to the complications of the needle insertion.</li> <li>▪ Temporary changes in mental function that can affect your sight, memory, movement and sensation. These occur shortly after the procedure but return to normal in a couple of days.</li> <li>▪ A stroke. This can cause paralysis and long-term disability.</li> <li>▪ Infection in the wound with resultant redness, pain and possible discharge or abscess formation.</li> <li>▪ Death during and after the angiogram due to severe complications.</li> <li>▪ Others, if any specify:</li> </ul>	<p><b>Contrast related risks:</b></p> <ul style="list-style-type: none"> <li>▪ Mild nausea.</li> <li>▪ Occasionally, mild reactions such as flushes, sneezing, vomiting, dizziness and vein or tissue injury.</li> <li>▪ Deterioration in kidney function.</li> <li>▪ Rarely, more severe reactions such as asthma, shock and convulsions.</li> </ul>

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<p><b>Likelihood of the Success Rate of Procedure</b> (To be documented by doctor)</p>	<p><b>Alternatives</b> (To be documented by doctor)</p> <ul style="list-style-type: none"> <li>▪ Carotid doppler ultrasound or other non-invasive imaging of the blood vessels.</li> <li>▪ Others, if any specify:</li> </ul>
<p><b>Specific Notes Related to Procedure</b> (Strike out if not required)</p>	<p><b>Precise Action Points Understood by the Patient/Substitute Decision Maker</b> (To be documented by patient/substitute decision maker in his/her language)</p>
<p><b>Patient's Authorisation</b></p> <ul style="list-style-type: none"> <li>• The doctor has explained my/the patient's medical condition and proposed treatment/procedure. I/we have been explained and have understood the intended benefits/risks known to be attached with the planned treatment/procedure including the risks that are specific to me/the patient and their likely outcomes.</li> <li>• The doctor has explained other relevant/alternate treatment options and their associated benefits/risks. The doctor has also explained the risks of not having the procedure. I have been given the choice to take a second opinion.</li> <li>• I was able to ask questions and raise concerns with the doctor about the procedure and its benefits/risks and my/patient's treatment options. My queries and concerns have been discussed and answered to my full satisfaction.</li> <li>• I understand that the treatment/procedure may include blood/blood product transfusion (for which a separate consent shall be obtained).</li> <li>• 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).</li> <li>• I understand that if organs or tissues are removed during the surgery that these may be retained for prescribed tests and shall be disposed of sensitively by the hospital as per the regulatory provisions.</li> <li>• The doctor has explained to me, that during the course of or subsequent to the operation/procedure, unforeseen conditions may be revealed or encountered which may necessitate urgent surgical or other procedures in addition to or different from those contemplated. In such exigency, I further request and authorise the above-named physician/surgeon or his designee to perform such additional surgical or other procedures as he or they consider necessary or desirable in my interest. I understand and agree that in such condition there will be no requirement of any additional consent from me or my family members/attendants.</li> <li>• I declare that no guarantee of whatsoever nature has been given by anyone as to the results that may be obtained.</li> <li>• I understand that I have the right to refuse treatment before surgery/procedure. I agree that any such refusal/withdrawal shall be in writing and acknowledged by the hospital and I shall be solely responsible for the outcome of such refusal.</li> </ul>	
<ul style="list-style-type: none"> <li>• 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 anywhere. <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b></li> <li>• For purposes of advancing medical education, I consent to the admittance of observers to the operating room.    <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b></li> </ul>	

Hospital Logo

Patient Identification Label

## Informed Consent for Cerebral Angiography

Patient Name:		Signature:		Date and Time:
Substitute Decision Maker Name:	Relationship:	Reason (patient is unable to give consent because):	Signature:	Date and Time:
Witness Name:	Relationship:		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 procedure. I have given the patient/ authorised representatives an opportunity to ask questions about any of the above matters and raise any other concerns. I have answered all their queries to the best of my knowledge.

Name and Signature of the Doctor with Reg No:	Date and Time:
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