ALASKA REGIONAL HOSPITAL

Invasive Neurovascular Procedures
CONSENT FORM

1. I hereby authorize Dr. _____to perform the procedure(s) listed below upon _____. The procedure(s) will be identified and marked by an (X) below:
(NAME OF PATIENT)

- ❑ Diagnostic Cerebral Angiogram
- ❑ Embolization of_____
- ❑ Vertebroplasty of_____
- ❑ Other:_____
- ❑ Moderate Sedation
- ❑ Deep Sedation
- ❑ General Anesthesia

2. The nature of the procedure has been explained to me in lay terms by my physician. I have been informed of the potential risks and benefits, as well as of alternative treatments. I acknowledge that no guarantee or assurance has been made as to the results or cure that may be obtained from this operation. I understand and accept the possibility of risks and complications. Possible risks include but are not limited to: vision loss; stroke; death; contrast allergy; bleeding requiring transfusion; vascular injury; groin injury; kidney failure; respiratory compromise from sedation; need for additional procedures or non-diagnostic imaging.

3. I hereby authorize and direct the above named physician to provide such additional services for me as he or she may deem necessary and reasonable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology and I hereby consent thereto. Although rare, several complications with anesthesia can occur and include the possibility of infection, bleeding, drug reactions, blood clots, permanent loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

4. I recognize that, during the course of the procedure, unforeseen conditions may require additional or different procedures than those set forth in Paragraph 1. I therefore further authorize and request that the above named physician perform such procedures as are in his professional judgment, necessary and desirable. The authority granted under this paragraph shall extend to remedying conditions that are not known at the time of the beginning of the procedure.

5. I hereby authorize the hospital Pathologist to use his discretion in the disposal of any severed tissue or body part.

6. I hereby authorize the above named physician or designee to record images of the procedure while under the care of Alaska Regional Hospital and agree that the hospital may use or permit other persons to use the images prepared there from for such purposes and in such manner as may be deemed necessary.

I HAVE READ THE ABOVE AND ALL THE BLANKS ARE FILLED AND I UNDERSTAND THE WORDS. I DO NOT REQUIRE ANY FURTHER EXPLANATION OF THE RISKS OR POTENTIAL COMPLICATIONS OF THIS PROCEDURE.

_____ Patient Signature	_____ Date	_____ Time
_____ Person Responsible for Patient Signature/Relationship	_____ Date	_____ Time
_____ Witness Signature	_____ Date	_____ Time

7. I hereby acknowledge that I have explained to the patient or responsible representative the material risks, hazards, complications and consequences which are, or may be, associated with the above stated operation(s) or procedure(s) and sedation if necessary.

_____ Physician Signature	_____ Date	_____ Time

PLACE PATIENT LABEL HERE