

Consent Form 1

University Hospitals Bristol



NHS Foundation Trust



Name of proposed procedure

Coronary Angiography

Patient's surname.....

Patient's first name.....

Date of Birth.....

NHS number (or other identifier).....

Responsible health professional.....

Job title.....

Please affix Patient Label here

Explanation of procedure

Your angiogram allows us to assess your heart arteries and heart function. You will receive a local anaesthetic in the wrist or groin, before insertion of a tube (sheath) which allows passage of fine tubes (catheters) to your heart arteries, under the direction of an x-ray camera. Contrast is injected into your arteries and a series of x-ray images are taken to assess for narrowings or blockages.

Statement of the health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits of this procedure are to gain assessment of the heart arteries.

Serious or frequently occurring risks:

Common side effects include: mild discomfort in the arm or leg, a warm flush with contrast injection, chest pain during balloon inflation, bruising in the wrist or groin after the procedure.

Serious but infrequent risks include: death, stroke, heart attack (composite < 1 in 1000), kidney failure, severe contrast allergy (1 in 500), haemorrhage.

Risks specific to your case include

Any extra procedures which may become necessary during or after the procedure

- ☐ Blood transfusion
- ☐ Surgical repair of groin artery (1 in 500), kidney dialysis (1 in 1000)

I have discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- ☐ Coronary angiography patient information booklet has been provided

The procedure will involve:

- ☐ general anaesthesia
- ☐ local anaesthesia
- ☐ sedation, if requested

Doctor's Signature Designation

Name (PRINT)

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way which I believe he/she can understand.

Signature..... Date.....

Name (PRINT).....

A COPY OF THIS CONSENT FORM HAS BEEN OFFERED TO THE PATIENT

Statement of Patient

SURNAME:

FIRST NAMES:

DATE OF BIRTH:

CONSULTANT:

BRI#:

SEX:



BHI

Bristol Heart Institute

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment on this form.

I understand that I cannot be guaranteed that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients undergoing general anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

Patient's Signature Date

Name (PRINT).....

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature Name (PRINT)

Confirmation of consent

(to be completed by a health professional on the day of the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature..... Date.....

Name (PRINT).....

Education & Research

University Hospitals Bristol NHSFT is a teaching trust and is therefore involved in Education & Research. In the course of your procedure, it may be necessary to remove tissue or fluid as part of the treatment or for analysis. Often this tissue or fluid can prove useful in education and research in the future and may be available on an anonymous basis as part of an ethically approved study. If you do not wish tissue or fluid to be retained for this purpose, please sign below.

I do not wish any retained tissue or fluid to be used for education or research purposes.

Patient's Signature Date

Important notes (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask patient to sign/date here).....