# Consent Form

Affix patient identification label in box below

NAME : BRIAN BELL
DOB : 11-02-1958
MRN : 0254876N
NHS : 4486496817

Postcode

## URGENT/EMERGENCY

## Coronary angiogram+/-Percutaneous Coronary Intervention

## Consent form for adults/competent children who have capacity to consent. Patient Agreement to Investigation or Treatment

**Newcastle upon Tyne Hospit[redacted]t**

Responsible Health professional [redacted] Job Title **Consultant Cardiologist**

Special Requirements (e.g. othe[redacted]cation method)

**Name of proposed procedure or course of treatment** Coronary angiogram +/- percutaneous coronary intervention (PCI)

**Statement of 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: To aid diagnosis and treatment of coronary artery disease

Significant, unavoidable or frequently occurring risks:

1/50-200 (0.5%-2%) damage to blood vessels in the leg
1/500-1000 (0.1%-0.2%) damage to blood vessel in the arm
1/200-400 (0.25%-0.5%) surgery to repair vascular damage
1/100-200 (0.5-1%) in hospital death
1/200-500 (0.2%-0.5%) bleeding into sac around the heart requiring a drain to be inserted
1/200-500 (0.2%-0.5%) impaired kidney function due to contrast dye
1/200-500 (0.2%-0.5%) heart attack
1/500 (0.2%) contrast allergy
1/1000 (0.1%) emergency cardiac surgery such as coronary artery bypass grafts
1/1000-1500 (0.05%-0.1%) stroke

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

- [x] Blood transfusion
- [ ] Radiology investigation – potential risk in pregnancy
- [ ] Care and treatment in a critical care unit
- [x] Other procedure emergency surgery as outlined above

**I have also 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.**

- [ ] The following leaflet/tape/disc/CD or DVD has been provided:

This procedure may involve:

- [ ] General and/or regional anaesthetic
- [x] local anaesthetic
- [ ] sedation
- [ ] Radiology investigation – potential risk in pregnancy

I am satisfied that the patient has capacity in line with the Mental Capacity Act to consent to the intended procedure

**SIGNATURE OF PERSON RECEIVING CONSENT**

Signed [redacted] Date 23/1/2019

Name (PR[redacted] Job title

**Contact details** (if patient wishes to discuss option later)

**Statement of interpreter** (where appropriate)

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

Signed

Name (PRINT) Date

Copy accepted by patient yes/no (please circle)

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## Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, 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 described on this form and I agree to being admitted to hospital for this purpose.

**I understand** that you cannot give me a guarantee 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 having general or regional 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 prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. In the event that I become unconscious, confused or do not have full capacity as a result of my illness or complications arising from the procedure(s), I consent to being kept in hospital for treatment.

I have listed below any procedures **which I do not wish to be carried out** without further discussion

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.....

**I understand** that information held by the NHS and records maintained by the General Register Office may be used to audit the quality and outcome of clinical treatment. I ☐ agree ☐ disagree to this.
**I understand** that for educational purposes, students may be involved in my examination during anaesthesia.
I ☑ agree ☐ disagree to this

Patient's Signature [redacted] Date 23/11/2019
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).**

Signed ..... Date
Name (PRINT).....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for 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.**

Signed ..... Date
Name (PRINT)..... Job title .....

**Important notes: (tick if applicable)**

☐ See also advanced decision to refuse treatment
☐ Patient has withdrawn consent (ask patient to sign/date below)

gned ..... Date .....