מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:	
שם משפחה:	שם פרטי:
שם האב:	תאריך לידה:
כתובת:	
טלפון:	**מדבקת פרטי מטופל**

טופס הסכמה: צינתור כלי דם
CONSENT FORM: ANGIOGRAPHY

Angiographies are performed to diagnose narrowing, obstruction, malformation or aneurysms of the blood vessels.

The procedure is performed under local anesthesia, and in children under general anesthesia, by the insertion of a catheter or needle, usually in the groin area or the hip, armpit or other areas, according to the requirements of the test. Contrast medium is injected through the catheter and the blood vessels are visualized using radiographs.

Therapeutic angiographies involve treatment of the blood vessel using a balloon, with or without the introduction of an accessory or stent, or the injection of thrombolytic therapy. If a problem that can be immediately treated is discovered during a diagnostic angiography, a therapeutic angiography is performed in continuation of the diagnostic angiography. **The patient must inform the attending physician or roentgenologist of any kidney disorder and/or iodine allergy before the procedure is performed.**

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
regarding the need for a diagnostic and/or therapeutic angiography, including treatment with a balloon and/or stent and/or thrombolytic therapy *. Specify other treatment: _____
_____(henceforth: "the primary treatment").

I hereby declare and confirm that I have been given an explanation concerning the side effects of the treatment, including pain and discomfort as a result of the local anesthesia and introduction of the catheter, and a sudden sense of heat as a result of the injection of the contrast medium.

In addition, I have been given an explanation concerning the possible complications of the catheterization, including hemorrhage in the insertion area, occlusion of the artery in the catheter region or a remote region, subcutaneous hemorrhage, pseudo-aneurysm and infection. In rare cases, the catheterized organ or limb may be damaged, leading even to loss of a limb and a stroke. I have also been given an explanation concerning the potential complications of the injection of contrast medium, including various degrees of allergic reactions and in very rare cases, damage to kidney function and aggravation of heart disease, and was told that in very rare cases these complications may even end in death.

I hereby give my consent to perform the primary treatment.

In addition, I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary treatment, or immediately following it, the need to perform additional or different procedures may arise in order to save my life or prevent physical harm, including additional.

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surgical procedures under general anesthesia that cannot be fully or definitely predicted at this time but whose significance has been made clear to me. I, therefore, also give my consent to such an extension, modification or performance of different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary treatment or immediately following it.

I also give my consent to the use of local anesthesia if the need arises and at the discretion of the attending physician, after having received an explanation concerning the possible risks of local anesthesia, including various degrees of allergic reactions to the anesthetic drug. If the need arises to perform the primary treatment under general anesthesia, I will be given an explanation concerning the anesthesia by an anesthesiologist.

I know and agree that the primary treatment and any other procedure will be performed by any designated physician, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

Date	Time	Patient Signature

Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician Signature	License No.

* Cross out irrelevant option.