Authorization for
Non-Invasive Electrophysiology / Arrhythmia Services

Patient’s Name: ________________________________

I hereby authorize Dr(s).____________________________ to perform the following procedure:

- Cardioversion
- Non-invasive electrophysiology study via ICD
- Head-Up Tilt Table Test
- Other:________________________

I understand that residents, medical students, physician assistants and/or advanced practice registered nurses may also be in attendance, and/or assisting in the performance, and/or performing significant tasks within the above specified procedure. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed procedure that require additional procedures or the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed procedure: (i) the nature and purpose of the proposed procedure; (ii) the foreseeable risks and consequences of the proposed procedure, including the risk that the proposed procedure may not achieve the desired objective; and (iii) the alternatives to the proposed procedure and the associated risks and benefits to such alternatives.

Specifically, in obtaining my informed consent to the surgery/procedure, I have been informed of the following reasonably foreseeable risks which include but are not limited to:

- Infection
- Device/lead malfunction
- Heart attack
- Blood clots
- Stroke
- Abnormal heart rhythm
- Allergic reaction to medications
- Death
- Other: __________________________

___________ Patient initials
Authorization for Surgery
Non-invasive Electrophysiology / Arrhythmia Services

I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed procedure.

I agree to the use of anesthesia and/or sedation/analgesia as required, and if applicable, the disposal of any tissue removed.

I also authorize the Hospital and the above-named physician(s) to photograph, video and/or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

____________________________________M. D.      Signed: ______________________________________  
(Patient or legally authorized representative)
Date: ____________ Time:__________     Date: ____________ Time:__________

Interpreter responsible for explaining procedures:
_________________________________________________ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [ ] BECAUSE:

___________________________________________________________________________________

_____________________________________ M.D.    Date: ____________ Time:__________
_____________________________________ Witness  Date: ____________ Time:__________