



Authorization for Invasive Electrophysiology/Arrhythmia Services

Patient's Name: _____

I hereby authorize Dr(s)._____ to perform the following surgery/ procedure:

- Device Implant: **Site of Implant:** Right Left
 - Pacemaker
 - Implantable Cardioverter Defibrillator (ICD)
 - Cardiac Resynchronization Therapy (CRT): (CRT-Pacemaker or CRT-ICD)
- Generator change
- Implantable Loop Recorder (Implant or Explant)
- Lead Revision
- Lead Extraction
- Electrophysiology Study
- Catheter Ablation (includes Electrophysiology study and trans-septal puncture if necessary) of:
 - Atrial Flutter and/or Supraventricular Tachycardia (SVT)
 - Atrial Fibrillation
 - Premature Ventricular Contractions (PVCs)
 - Ventricular Tachycardia
 - AV Node
 - Other: _____
- Other/Comments:_____

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 medical/surgical tasks within the above specified surgery/procedure. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery/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 surgery/procedure: (i) the nature and purpose of the proposed surgery/procedure; (ii) the foreseeable risks and consequences of the proposed surgery/procedure, including the risk that the proposed surgery/procedure may not achieve the desired objective; (iii) the alternatives to the proposed surgery/procedure and the associated risks and benefits to such alternatives; and (iv) the reasonably foreseeable risks and alternatives to the transfusion of blood and blood products should I need a blood transfusion.

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:

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Infection • Perforation of heart • Skin reaction from X-rays • Device / lead malfunction • Pulmonary vein narrowing • Other: _____ | <ul style="list-style-type: none"> • Heart Attack • Damage to blood vessels • Death • Abnormal heart rhythm • Damage to the heart's electrical system | <ul style="list-style-type: none"> • Bleeding • Allergic reaction to medications • Blood clots • Stroke • Damage to structures around the heart. |
|---|--|---|

_____ Patient initials



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**Authorization for Surgery
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 surgery/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 surgery/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: _____