



Authorization for Transcatheter Aortic Valve Replacement

Patient's Name: _____

I hereby authorize Drs. _____
to perform the following surgery and/or special procedure/treatment:

Transcatheter Aortic Valve Replacement

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 and/or special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery and/or special procedure/treatment that require 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/treatment: (I) the nature and purpose of the proposed surgery/procedure/treatment; (II) the foreseeable risks and consequences of the proposed surgery/procedure treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective; (III) the alternatives to the proposed surgery/procedure/treatment 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 and/or special procedure, I have been informed of the following reasonably foreseeable risks:

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Death • Kidney Failure, Possibly requiring Dialysis • Emergent Cardiac Surgery • Device Malfunction • Blood Leakage Around the Device • Need for a temporary or permanent pacemaker • Prolonged ICU or Hospital Stay • Hemolysis or Hemolytic Anemia • Hypertension • Allergic Reaction to X-Ray Dye | <ul style="list-style-type: none"> • Stroke or Transient Ischemic Attack • Damage to a Blood Vessel Requiring Surgical Repair • Heart Failure • Device Malposition or Movement • Device Thrombosis • Pericardial Effusion/Cardiac Tamponade • Blood Transfusion • Hypotension • Adverse Reaction to Anesthesia • Excessive Bleeding | <ul style="list-style-type: none"> • Heart Attack • Damage to the Heart Muscle, Coronary Arteries or Cardiac Valve • Respiratory Failure • Inability to Implant Device • Abnormal Heart Rhythm • Esophageal Perforation or bleeding • Hematoma/Pain at a Wound Site • Non-Emergent Re-Operation • Infection • Nerve Damage |
|---|---|--|

- Any of these complications may cause death.

_____ **Patient initial**



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 treatment and/or special 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 treatment.

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 documented 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)

Date: _____ **Time:** _____ **Date:** _____ **Time:** _____

Interpreter responsible for explaining procedures and special treatment: _____

_____ **Date:** _____ **Time:** _____
(Signature – interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [] BECAUSE: _____ _____ _____			
Witness: _____ M.D.		Witness: _____	
Date: _____ Time: _____		Date: _____ Time: _____	