Hartford Hospital
A Hartford HealthCare Partner

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Authorization for Transesophageal Echocardiogram

Patient's Name: _____

I hereby authorize Dr. _____ to perform the following special procedure:

❑ Transesophageal echocardiogram

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 special procedure. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed special procedure 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 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; (iii) the alternatives to the proposed procedure and the associated risks and benefits of 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 special procedure, I have been informed of the following reasonably foreseeable risks, including, but not limited to:

For transesophageal echocardiography:
• Minor bleeding from the lips, mouth, or throat (up to 10%)
• Hoarseness (up to 10%)
• Bronchospasm or laryngospasm (trouble breathing) (0.1%)
• Damage to teeth or dental appliances (0.1%)
• Arrhythmia (0.1%)
• Esophageal perforation (<0.01%)
• Major bleeding (<0.01%)
• Death (<0.01%)

For conscious sedation:
• Adverse reactions to medications
• Respiratory suppression
• Aspiration

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 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 procedure.

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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.

_____ Signed: _____

MD, APRN, PA (Patient or legally authorized representative)

Date:_____Time:_____ Date:_____Time:_____

Interpreter responsible for explaining procedures and special treatment:

_____ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [❒] BECAUSE:

_____

_____ M.D. Date:_____Time:_____

_____ Witness Date:_____Time:_____