

Heart Cath Check List

PATIENT NAME: _____

PRE-OP DATE / TIME: _____

CATH DATE / TIME: _____

ORDERS: _____

OFFICE NOTE: _____

CXR: _____

LABS: _____

CONSENT FORM: _____

NOTIFY DONNA DEGENNARO: _____
DONNA.DEGENNARO@FLAGLERHEALTH.ORG

STAFF PREPARING: _____ DATE: _____

STAFF RECEIVING: _____ DATE: _____

Heart Cath Instructions

PATIENT NAME: _____

PRE-OP

*** ARRIVE IN OUTPATIENT AT _____ AM/PM ON _____ ***

HEART CATH PROCEDURE INSTRUCTIONS

*** ARRIVE IN OUTPATIENT AT _____ AM / PM ON _____,
_____ ***

*** NOTHING TO EAT OR DRINK AFTER MIDNIGHT ***

*** IF YOU TAKE COUMADIN, PLAVIX, OR ASPIRIN, STOP THIS MEDICINE ON
_____ ***

*** TAKE YOUR BLOOD PRESSURE MEDICINE AT YOUR NORMAL TIME ***

*** DO NOT TAKE ANY DIABETIC MEDICINES PRIOR TO COMING ***

*** BE SURE TO HAVE A DRIVER HOME OR YOU WILL NOT BE PERMITTED
TO LEAVE ***



Patient Label

CONSENT FOR OPERATION AND/OR INVASIVE PROCEDURE

Verification of Procedure(s) to be performed (*Must include laterality, if pertinent):

Right heart cath

to be performed by _____ and such assistants as he/she may designate.

Acknowledgement of Informed Consent

Provider's signature

Date

Time

- I hereby confirm that I have given consent to the above named procedure performed by the healthcare provider(s) named. I acknowledge that my provider has explained proposed care, treatment and services, potential benefits, risks and side effects of the procedure, as well as the likelihood of achieving goals of treatment and any potential problems that might occur during my recuperation.
- I acknowledge that my provider has explained to me the reasonable alternatives to proposed care, treatment and services, as well as risks, benefits and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment and services.
- I acknowledge that my provider has explained the specific risks of the proposed procedure(s) named and possible complications, including but not limited to the chance of failure of the procedure and the possibility of unplanned injuries to organs, nerves or blood vessels including but not limited to inadvertent puncture, laceration or tearing of other internal organs and consequent bleeding and the need for additional surgery/procedures.
- I also acknowledge that I have been informed that there are other risks with the performance of any invasive procedure, including but not limited to severe blood loss, infections, cardiac (heart) failure or cardiac arrest, and others up to and including death.
- If my provider determines that a pelvic examination (an internal examination of female reproductive organs performed manually, with the provider's gloved hand or instrumentation) is necessary, or becomes necessary, I consent to same.
- I recognize that during the course of the procedure, unforeseen conditions may require additional or different procedures than that listed above. I therefore give my consent and authorize my provider(s) and/or his/her assistants to perform such procedures as are, in the exercise of professional medical judgement, necessary and desirable including but not limited to procedures involving additional operations or procedures.
- If this procedure involves childbirth, I authorize the above named provider and such assistants as may be designated by him/her to perform such procedures for and to render treatment to my baby as necessary and desirable in the exercise of professional judgment.
- I understand that surgically removed tissue may be examined and retained by the Hospital for medical/diagnostic purposes. I consent to the disposition of tissue or parts removed during such treatment by the Hospital in accordance with customary practice. I understand that tissue and/or devices or implants removed will not be released by the Hospital without appropriate authorization.
- I understand that a technical support representative/company representative may be requested during my procedure and deemed necessary by my surgeon. I consent to the presence of such support representative(s) for my procedure(s).
- I consent to the possibility of observer(s) or student(s) observing my procedure or surgery.
- I have read or had read to me and fully understand this consent. I have been given the opportunity to ask questions and have my questions answered.

() PATIENT IS A MINOR

() PATIENT IS UNABLE TO SIGN

Patient's signature: _____

Date: _____ Time: _____ (a.m./p.m.)

Witness/Interpreter signature: _____

Date: _____ Time: _____ (a.m./p.m.)

Authorizing signature: _____

Relationship to patient: _____

Date: _____ Time: _____ (a.m./p.m.)



