INTRODUCTION:

Your physician has requested that you undergo a pulmonary arteriogram to further diagnose and/or treat a pulmonary arteriovenous malformation (PAVM-shunt in your lung). Based on the findings of this study, embolization (deliberate blockage of the shunt) may be performed. Treatment of the PAVM(s), if present, is indicated to prevent stroke or brain infection. We are asking you to read and sign this form so that we can be sure you understand the procedure and potential benefits, along with the associated potential risks, complications, alternatives, the likelihood of achieving the goals, and the recuperative process. Please ask questions about anything on this form that you do not understand.

PROCEDURE:

A pulmonary arteriogram involves the placement of a plastic tube (catheter) into a vein in either your leg or your neck. Some numbing medicine will be injected in the skin over the vein that will be used before the catheter is inserted. Intravenous medications may also be given to you to make you more comfortable and relaxed. This is known as moderate sedation. Once the catheter has been placed into the vein, it will be advanced through the blood vessels until it reaches the vessels in your lungs. During this time, blood pressure measurements will be taken through the catheter. In addition, x-ray contrast material (x-ray dye) will be injected through the catheter and x-ray pictures taken. You may be asked to hold your breath for several seconds as these pictures are taken. During the injection of x-ray contrast material, you may experience a warm feeling or a strange taste in your mouth. Both of these sensations are temporary and will go away soon. Depending on the results of the pulmonary arteriogram, embolization may be performed. At the completion of the pulmonary arteriogram, the catheter will be removed and pressure will be applied to the insertion site until the bleeding has stopped. To help prevent bleeding, it will be very important for you to lie flat in bed without moving your leg for up to four hours. If the pulmonary arteriogram shows a PAVM(s), embolization will be performed using platinum coils, stainless steel coils or other vessel closing devices to stop blood flow through the PAVM (shunt). The vessel closing device will be left in place at the completion of the procedure.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the catheter insertion site, bleeding at the site, injury to a blood vessel, infection which may result in an infection of the blood stream, the development of a blood clot, disturbances in heart rhythm (arrhythmia), non-target embolization (coils or devices going through the shunt to an undesired location) and stroke. Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function. The medications used for the moderate sedation are associated with the risks of aspiration (inhaling food or liquid into your lungs) or respiratory depression. In addition to these potential risks associated with the procedure, the x-ray contrast material, and the moderate sedation medications, there may be other unpredictable risks including death.

(Complete this paragraph if applicable or document “NA”)

Due to your additional medical history of__________________________ added risks for you include but are not limited to:

__________________________

__________________________

__________________________

ALTERNATIVES:

There may be other methods to diagnose and/or treat your PAVM, including surgery, or you could decide not to have the PAVM treated and accept a risk of stroke or brain infection. If you are unsure about having a pulmonary arteriogram, along with possible embolization performed, please discuss these other alternatives with your physician.
Consent for Pulmonary Arteriogram and Embolization

AGREEMENT:

The information on this form was explained to me by ______________________. I understand the information and I have had the opportunity to ask any other questions I might have about the procedure, the reasons it is being performed, the associated risks, and the alternatives to the procedure. I agree to undergo the procedure to be performed by an authorized member of the Division of Vascular and Interventional Radiology and his/her associates, assistants, and appropriate hospital personnel, and accept the risks. I also agree that fellows, residents and surgical assistants may participate in significant tasks that are part of the procedure. In addition, I agree to have any other appropriate personnel present for the procedure.

I assign to the University of Pennsylvania Health System (“Health System”) all rights to any tissues, organs, cells, body parts, and/or body fluids that may be removed during this procedure and I authorize the Health System to use or dispose of such specimens according to its standard practices.

The University of Pennsylvania Health System routinely suspends all resuscitative aspects of living wills and Do Not Attempt Resuscitation orders during the pre-procedure, procedural and post-procedural period, unless you specifically tell us otherwise. This applies to all invasive and operative procedures.

Signature: ___________________________ Date: _________ Time _______

Patient

Signature: ___________________________ Date: _________ Time _______

Authorized Healthcare Professional obtaining and witnessing patient’s signature

Signature: ___________________________ Date: _________ Time _______

Attending physician (if applicable)

To be used if the patient is a minor, unconscious, or otherwise lacking decision making capacity.

I, _____________________________, the ___________________________

Relationship to patient

of _____________________________ hereby give consent.

Signature: ___________________________ Date: _________ Time _______

Legally Authorized Representative

Signature: ___________________________ Date: _________ Time _______

Authorized Healthcare Professional obtaining and witnessing representative’s signature

Signature: ___________________________ Date: _________ Time _______

Attending physician (if applicable)

Signature: ___________________________ Date: _________ Time _______

Witness to telephone consent