University of Pennsylvania Health System
Department of Radiology
Division of Vascular And Interventional Radiology

Consent for Dialysis Fistulogram and Possible Angioplasty, Stent Placement or Thrombolytic Therapy

INTRODUCTION:

Your physician has requested that you undergo a dialysis fistulogram to further assess your dialysis graft/fistula. Based on the findings of this study, additional interventions, such as an angioplasty, stent placement, or thrombolytic therapy may be performed. 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 dialysis fistulogram involves the placement of one or more plastic tube(s) (catheters) into your dialysis graft/fistula. Some numbing medicine will be injected in the skin over the graft/fistula 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 graft/fistula, it will be advanced through the blood vessels. During this time, 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 fistulogram, an angioplasty, stent placement, or thrombolytic therapy may be performed. At the completion of the fistulogram, the catheter(s) will be removed and pressure will be applied to the insertion site(s) until the bleeding has stopped. If the fistulogram shows an area of blockage, an angioplasty may be performed in an attempt to open up the area. This involves the insertion of a special tube, which has a tiny deflated balloon. The balloon is positioned at the site of the blockage and is then inflated. Following an angioplasty, if there still is not enough blood flow through the area of blockage, a metal mesh tube (stent) may be placed at the site. The stent will widen the vessel and improve the blood flow.

If the arteriogram shows that a blood clot is blocking one of your vessels, a special drug or mechanical device may be used to dissolve the clot. This is known as lytic therapy. If a drug is used, this therapy may take 24 hours or more and may require that you be admitted to the Intensive Care Unit for monitoring while this drug is being given. Additional arteriogram x-ray pictures may be taken to determine the progress of the dissolving blood clot.

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 (embolization), and stroke. Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function if you have any residual 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 procedures that can be performed to further evaluate your circulation and/or treat an area of blockage. If you are unsure about having a fistulogram, along with a possible angioplasty, stent placement, or thrombolytic therapy performed, please discuss these other alternatives with your physician.

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

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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