Russell C. Lam MD PA
8210 Walnut Hill Lane Suite 505
Dallas, Texas 75231

CONSENT TO OPERATION OR PROCEDURE AND ANESTHESIA

I request and consent to a surgical procedure called: Carotid Angiogram, Mesenteric Angiogram, Renal Angiogram. Possible Angioplasty/Stent, Abdominal Aortogram with peripheral run off, Peripheral Angioplasty/Stent/Atherectomy.
(Practitioner must describe procedure in non-medical terms)
and I understand that the purpose of this procedure is to treat my condition known as Peripheral Arterial Disease
This procedure will be performed by Dr. Russell Lam / Dr. Cassidy Duran / Dr. Esther Mihindu

I have been advised that this procedure may have potential benefits, risks, or side effects associated with it including but not limited to **1. Bleeding, 2. Infection, 3. Pain, 4. Renal failure or damage to kidneys, 5. Rupture of vessel requiring emergency surgery, 6. Damage to access artery in leg, 7. Death, 8. Myocardial infarction, 9. Stroke, 10. Loss of Limb, 11. Loss of sensation in legs, 12. Allergic reaction to injected contrast media, 13. Inability to open vessel, 14. Closure of vessel.** Including potential problems that might occur during recuperation. I have been advised of the alternatives, the risks, benefits and side effects related to the alternatives.

- I **understand** that the procedure may be performed at our office Angio Suite at Russell C. Lam MD PA, or Lam Vascular and Associates, 8210 Walnut Hill Lane, Building 1, Suite 505, Dallas, Texas 75231 or at a hospital setting and I have been given the opportunity to choose the location which suits my needs.
- **I consent** to the administration of anesthesia and related drugs, as deemed necessary by the staff members from Russell C. Lam, MD, PA.
- **I understand** that unforeseen complications of conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.
- **I understand** that portions of the operation may be photographed or videotaped. I consent to this as long as my identity is not revealed. I understand that these photographs may be used for teaching. I also understand that residents, medical, nursing and allied health students/trainees may be present during the procedure and they may observe or assist in my care, under the direction of my surgeon and other hospital staff members.
- **I understand** that in the event one or more of my health care providers sustains a needle stick/sharp injury or exposure to my blood/bodily fluids that blood may be drawn and may be tested for hepatitis and the result of that hepatitis testing disclosed to the health care providers who sustained the exposure.
- **I also understand** that a sales/clinical representative may be present during the procedure but may not participate in the procedure.
- **I understand** that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death.
- **I impose** no specific limitations or restrictions on my treatment other than: _____

(Patient must specify restriction or write "None")

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. All blank spaces are completed or lined out, prior to my signing this document.

_____	_____	_____	_____
Signature of Patient, Parent*, Guardian, Health Care Agent* or other representative of patient	**Relationship (if other than patient)**	**Date**	**Time**

*If other than patient, provide a reason _____

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Signature of Witness **Title or Relationship to Patient** **Date** **Time**
(Age 18 or older, other than Practitioner Performing procedure)

___ An interpreter or special assistance was used to obtain consent from this patient _____
(Name of Interpreter)

_____ I have reviewed the recent history and physical examination completed within the last 30 days and have noted that there are no significant changes.

Signature of Practitioner **Date** **Time**

I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, including the possible risks of not receiving care, treatment and services.

Signature of Practitioner **Date** **Time**

ANESTHESIOLOGY SITE/SIDE VERIFICATION

I confirm that I have verbally verified the correct operative / procedural site / side with the patient. If the patient's status prohibits verbal verification of correct site / side, verification obtained utilizing the medical record. I have reviewed the anesthesia, relevant risks, benefits and alternatives.

Signature of Physician **Date** **Time**