LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL –MUHLENBERG
BETHLEHEM, PA

0 0 1

PLACE PATIENT LABEL HERE

CONSENT FOR TREATMENT OF ACUTE ISCHEMIC STROKE

What is Tissue Plasminogen Activator (tPA)?
Tissue plasminogen activator or tPA is an FDA approved medication used for acute stroke that breaks up blood clots and opens blocked blood vessels in your body. If you have a stroke caused by blocked blood vessels, tPA may help to return blood and oxygen to your brain. If you get tPA early, it may reduce the damage to your brain caused by the stroke. Quick treatment could save your life or improve your conditions.

What are the risks?
Because of its strong blood thinning action, tPA can cause more bleeding into or around the brain as well as to other parts of the body. This can cause a worsening of your condition and even death. In most situations, the benefits of this medicine far outweigh risk of harm, and for most patients, we recommend its use.

How will I get the tPA?
You get tPA through a vein (IV). There are special times when your doctor may wish to give it through an artery (IA), which is not specifically approved by the FDA, either as a sole treatment, or in combination with IV therapy; therefore is considered of as an "off-label" treatment.

Why would my doctor want to use tPA through an artery?
Giving tPA through a blocked artery, may save time and return blood flow to the brain faster. Known as interventional radiology therapy, this process uses X-ray pictures to view blocked blood vessels and lets your doctor add tPA right into the blood clot with special tools to retrieve and remove stubborn clot that won't break up with tPA given by itself. This helps to break up the clot and return blood flow your brain.

If Interventional therapy is being considered:

I do hereby request the Lehigh Valley Health Network Stroke Team to perform upon _____ the following operation/procedure ***Cerebral Arteriogram with possible treatment of neck/brain artery blockage/narrowing using medical/mechanical devices including possible use of off-label (medical/mechanical) therapy***.

- I understand that the procedure is to be performed at a teaching hospital and may involve resident doctors, medical students and other students and providers under the direction of my doctor.

The above treatment / surgery: ☐ right ☐ left (if it applies) will be done for the diagnosis and treatment of ***stroke***.

If conditions arise during the course of the procedure or anesthesia which make it medically advisable to immediately extend the procedure or to undertake procedures different from those set forth above. I authorize the physician(s), to perform such additional procedures as are advisable in the judgment of the physician(s) or other providers.

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL –MUHLENBERG
BETHLEHEM, PA

PLACE PATIENT LABEL HERE

CONSENT FOR TREATMENT OF ACUTE ISCHEMIC STROKE

Sedation and Anesthesia

I have been told that pain during my procedure will be kept under control by the use of medications, including local anesthetics, intravenous sedating medications or drugs to put me to sleep (general anesthesia).

- I understand during certain procedures my physician will give me medicines for pain and that I will be awake for the procedure. I further understand that in some instances during my procedure my physician may determine help from an anesthesia provider is needed. I give permission for this care.
- I understand that the anesthesia used to sedate me or put me to sleep during surgery (general anesthesia) is not under the control of my surgeon.

I understand my need for treatment and that the purpose of the procedure is ***to open one or more blocked arteries supplying the brain.*** I know the practice of medicine and surgery is not an exact science. I know that no promises have been made about the outcome of this procedure / surgery.

Risks

The following general risks with this procedure / surgery have been explained to me. These risks include but are not limited to:

- infection
- bleeding
- injury to the surrounding structures
- progressive or additional stroke
- hemorrhage
- blindness
- paralysis
- kidney damage
- contrast allergic reaction
- other organ damage
- vascular injury
- death

Additional Risks

I understand the additional risks and results for this procedure / surgery may include:
No improvement in my condition or prognosis. There is no guarantee of neuro recovery.

Benefits

The following benefits for this procedure / surgery have been explained to me. These benefits include but are not limited to: _____

_____

Other Options (alternatives)

I have been told about possible alternative methods of treatment: These include but are not limited to: ***medical therapy,***

I have been told about the possible effect of no treatment including: ***progressive stroke***

If my procedure requires Radiation:

These procedures may involve the use of x-rays. Due to the occasional prolonged nature of some of these procedures, there is a possibility of skin reactions in the area receiving the x-rays. These reactions are usually temporary and may cause reddening of the skin or hair loss. These reactions are often delayed and may not occur until two to four weeks following your procedure.

PLACE PATIENT LABEL HERE

CONSENT FOR TREATMENT OF ACUTE ISCHEMIC STROKE

Consent for Blood and Blood Products

I understand that blood and/or blood products may be administered during this procedure and my physician has explained to me the possible benefits, risks and complications of receiving blood and/or blood products.

Consent to Take Part in Study or Education Related to My Care

For the purpose of advancing medical education, I consent to the admittance of observers and technical representatives to the Radiology room and to the possible photographing and/or televising of the procedure to be performed provided my identity is not revealed by the pictures or by descriptive text accompanying them. I waive my right to inspect and/or approve the finished product and its specific use. I understand that the procedure is to be performed at a teaching hospital and may involve resident doctors, medical students and other students and providers under the direction of my doctor.

Consent for HIV Testing

☐ If any healthcare provider is exposed to my blood, I agree (consent) in advance to the taking of blood samples for HIV testing prior to, during or after the course of my procedure. I have been given the option to opt out of this testing. If I decline testing, this section will not be checked.

Signatures

I understand that I may withdraw my permission (consent) for this procedure / surgery at any time before it is performed. My signature below means that:

- I have read and understand this consent form.
- I have been given all the information I asked for about the procedure / surgery, the risks and other options.
- All my questions were answered.
- I agree to everything explained above.

PATIENT OR (AUTHORIZED REPRESENTATIVE) NEXT OF KIN	DATE	TIME

WITNESS TO SIGNATURE (Required if patient or authorized representative is unable to sign or signs with a mark)	DATE	TIME

I have discussed the procedure as outlined above with the patient or the patient's authorized representative and answered all questions.

SIGNATURE OF PHYSICIAN	DATE	TIME

If it applies, the above information was translated and/or the consent was read in _____ language by _____ (Print Interpreter Name).

SIGNATURE OF INTERPRETER (if it applies)	DATE	TIME