

## Cardiology

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## Information and patient consent form Cardioversion of atrial fibrillation / flutter

Dear patient,

This information sheet and an informed consent discussion state the reason, procedure and possible complications of the intended cardioversion.

### Why a electrocardioversion?

Your doctor has diagnosed that you have atrial fibrillation or flutter (a cardiac arrhythmia with rapid beating of the atria). This cardiac arrhythmia may cause symptoms such as shortness of breath, dizziness or a restriction of activity and impair the function of your heart in the medium-term. In addition to drug and interventional treatment of this arrhythmia, which previously was not effective, not possible or did not makes sense at all, there is a treatment using electric shock that is called cardioversion.

### What is a electrocardioversion and how does it work?

The treatment takes place in our monitoring station. Two large-area electrodes are placed on your chest (see figure on the back). A short current impulse is emitted through the electrodes, which ends the existing cardiac arrhythmia and ensures that your heart beats again normally. In order to make sure that you do not feel this current impulse, a brief anesthesia is administered. A pain killer and a strong, short-acting sleeping aid are injected intravenously and oxygen is also administered via a mask. The anesthesia usually lasts only a few minutes.

In order to ensure that no stomach contents enter the trachea or lungs during the brief anesthesia, you must fast on the day of the treatment (that is, do not eat or drink anything for at least 6 hours before the treatment). The intake of tablets with a small sip of water is allowed. Any dentures will be removed just before treatment.

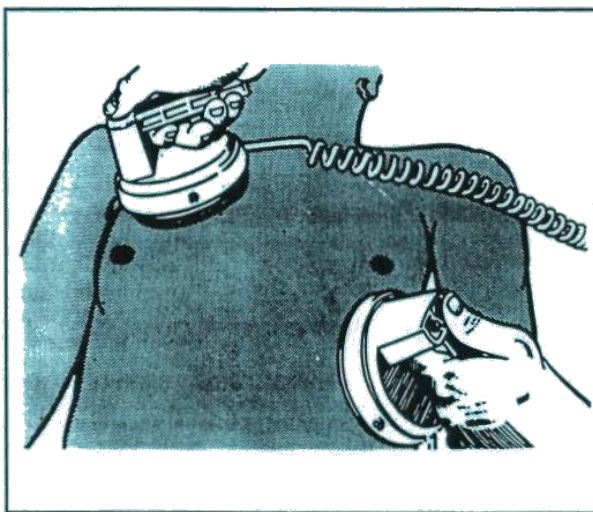
After treatment, you will stay at the monitoring station for 1 hour. During this time your heart rhythm, blood pressure and breathing will be continuously monitored until the effect of the anesthetic has completely faded away.

Proper blood thinning is very important. Your doctor will therefore exactly ask if the appropriate medication has been taken correctly. We will strictly ask you, in your own interest, to tell us the truth. If necessary, the extent of blood thinning is tested again with a Quick / INR determination.

### **Potential complications:**

Although this electric treatment can be usually performed without any problems, side effects and, in rare cases, complications may occur. Skin irritation (similar to a mild sunburn) frequently occur on the two points on the chest, through which the current impulse is emitted. These are, however, temporary in nature and can be easily treated with an ointment. Another possible side effect is a hypersensitivity reaction to an anesthetic. If you already have an allergic reaction to a medication, please let us know! Serious complications such as incidents related to anesthesia, occurrence of other cardiac arrhythmias or flushing out of blood clots from the heart (embolism) are extremely rare.

### **Figure:**



### **Space for a sketch / personal notes:**

**Please contact us,**

if you do not understand something or if something seems to be important that was not mentioned in this document or in the personal consultation with your doctor.

**Declaration of consent**

Dr. med. ....

held an informed consent discussion with me. I have understood the information provided to me and could make all the pertinent questions. After sufficient time to think and answering of all my questions I hereby declare myself ready for the proposed therapy. I express my consent for any follow-up procedures that may become necessary.

Signature of patient: \_\_\_\_\_

Signature of doctor: \_\_\_\_\_

Place and date: \_\_\_\_\_

**Consent to data collection and evaluation**

I agree with the collection and analysis of scientific data of my treatment in an encrypted, electronic form. If necessary, the traceability of data for quality assurance is ensured. We assure you with an unrestricted right of access to inspect the data archived about you.

Signature of patient: .....

Place and date: .....