

## Cardiology

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### Information and patient consent form **Implantation of a long-term ECG device (Reveal)**

Dear patient,

You were referred to us for the implantation of a Reveal recorder. The Reveal is about the size of a USB stick (approx. 5x2 cm) and serves to continuously record your ECG to analyse it in case of certain symptoms. Mostly it comes down to the clarification of fainting where it has to be determined whether a slow or fast heart rhythm is the cause for it.

#### **Implantation:**

For this intervention, only a local anesthetic is necessary. The Reveal is implanted on the left side of the sternum a few centimeters above or below the nipple. It is important that the device is present at the left side as it should show the electric potentials of the heart as well as possible. A nearly 2 cm wide section is cut and then a small cavity is created into which Reveal can be inserted. Following this, the usual wound closure is performed. Usually, the procedure takes 10-20 minutes.

#### **Possible complications and follow-up checks:**

After the intervention, you may go back home or to work. An impairment is not expected. The only complication that may occur is a small local haematoma. After 10-14 days, your family doctor must remove the sutures, unless they are absorbable. Every 3 months, checkups are carried out here at the hospital. The Reveal can be removed if a clear diagnosis could be made or at the latest when the battery runs low, which usually occurs after 2-3 years.

**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: .....