

Kardiologie

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Consent Form

For the catheter treatment of a leak between the right and the left heart chambers, that is, atrial defect, closure of an open foramen oval (ASD, PFO) of a ventricular septal defect (VSD)

Dear patient

I was informed about the planned intervention and agree to it.

I have been informed about the purpose, the chances of success, the risk and other treatment options. I know that while the catheter treatment is being performed my physician must take additional measures depending on the situation in order to achieve the best possible result. This may make the use of ultrasound examination through the esophagus (transesophageal echocardiography) or an ultrasound examination in the heart (Intracardiac ultrasound examination) necessary. I know that in a few cases, the filter placement cannot be carried out and an emergency medical treatment or planned surgical treatment must be performed.

I have been informed that in rare cases (< 1 percent), the filter can loosen shortly after being used and then must be removed by means of catheter or by operation from the heart or a blood vessel. I know that because of the treatment anticoagulant medications need to be taken for half a year. Other serious complications include air embolism in the arteries or injury to blood vessels. These usually occur very rarely (< 1 percent). I know that after the filter implantation disorders of cardiac rhythm may occur, which must be treated with medication.

I have been informed that in a few cases a gap can persist and a second treatment may become necessary.

I was also informed about the general risks of cardiac catheter examination. I know that bleeding at the injection site, and disorders of the cardiac rhythm can occur and need to be treated. Other serious complications (severe allergy to drugs used, circulatory disorders of the arteries and formation of clots in the arteries, kidney disorders, strokes, etc.) occur in less than 1 percent of patients.

Since there is a small risk of bacterial infection, I will receive an antibiotic and in case of dental or other interventions or febrile illnesses, I must take antibiotics for a couple of months for prevention.

I have understood the information passed on to me. My questions were satisfactorily answered.

Space for your 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: