**MASSACHUSETTS GENERAL HOSPITAL**

# PROCEDURE CONSENT FORM
# Intra-arterial Thrombectomy

**PATIENT**:

**UNIT NO**:

**PATIENT IDENTIFICATION STAMP**

I have explained to the patient/family/guardian the nature of the patient's condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches. I have discussed the likelihood of major risks or complications of this procedure including (if applicable) but not limited to loss of limb function, brain damage, paralysis, hemorrhage, infection, complications from transfusion of blood components, drug reactions, blood clots and loss of life. I have also indicated that with any procedure there is always the possibility of an unexpected complication.

Additional comments (if any):

Dr. _____ has explained to me (or my family member) why they believe a stroke is happening and which of the available methods would be most likely to improve my condition. They have explained the risks and benefits of the drugs and techniques available to dissolve blood clots in the brain and possible alternative treatments. They have recommended the use of **INTRA-ARTERIAL THROMBECTOMY** through the artery to remove the occlusion/blockage in the blood vessel. This includes devices (stentrievers, vacuum systems, wires, angioplasty balloons, and others) or rarely medication (tPA) and may require general anesthesia.

I understand the emergent nature of this procedure.

**Cerebral Angiography and Intra-Arterial Thrombolysis with or without General Anesthesia:**
The risks include:

- Death, Stroke or permanent neurologic injury (paralysis, coma, etc)
- Worsening of stroke symptoms from swelling or bleeding in the brain
- Injury from clot fragments to other parts of the brain, or other vessels
- Need for carotid artery stenting or balloon angioplasty
- Bleeding in other parts of the body, especially the groin
- Need for blood transfusions to replace blood or clotting factors
- Vessel injury including rupture or occlusion, possibly requiring surgery
- Kidney failure or allergic reaction to contrast dye or medications
- Radiation complications
- Infection
- Anesthesia complications such as: airway damage (including injury to teeth), inability to extubate (come off the breathing machine), heart attack or cardiovascular/respiratory compromise
- Other unexpected complications

All questions were answered and the patient/family/guardian consents to the procedure.

_____ M.D. DATE: _____
(Physician's Signature)

_____
Dr. _____ has explained the above to me and I consent to the procedure. I understand that Massachusetts General Hospital is an academic medical center and that residents, fellows and students in medical and allied disciplines may participate in this procedure. In addition, I understand that tissue, blood or other specimens removed for necessary diagnostic or therapeutic reasons may subsequently be used by the Hospital or members of its Professional Staff for research or educational purposes.

_____
(patient's/family's/guardian's signature *)

*(If patient's signature cannot be obtained, indicate reason in comments section above)

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Reviewed/Approved by: Thabele (Bay) M. Leslie-Mazwi, M.D