

<b>CONSENT FORM</b>  <b>TRANSOESOPHAGEAL ECHOCARDIOGRAM (TOE)</b>	U.R. No	(Please place patient label here)	
	Surname		
	Given Names		
	D.O.B.		Sex    M    F
	GP		

**A. INTERPRETER NEEDS**

An Interpreter Service is required      yes  no   
 If yes, is a qualified Interpreter present yes  no

**B. CONDITION AND PROCEDURE**

Dr Allada has explained that I have the following condition:

.....

.....

This condition requires a test called a Transoesophageal Echocardiogram (TOE). This is a special type of heart ultrasound. Pictures of the heart are taken from inside the body. This gives better quality pictures of the heart.

The equipment that takes the pictures is called the "ultrasound probe" The probe is put into the mouth and it passes down the connecting tube to the stomach. This connecting tube is called the oesophagus.

Dr Allada will see the back of the heart from this position.

**The following procedure will be performed:**

A small needle will be inserted into the back of your hand. The nurse will give you some medication to help you relax. The back of your throat will be sprayed with a local anaesthetic. This will make it easier to swallow the probe. The probe will be in place for about 15 minutes.

Your pulse, blood pressure and electrocardiogram will be watched during the test. If Dr Allada is worried about these, the test will be stopped.

At the end of the test, the probe will be removed. You will be taken to the recovery area. Nursing staff will monitor your pulse, blood pressure and general condition.

Your throat will feel numb after the test. You will not be able to eat or drink anything for two hours after the test or until the numbness goes away.

**You will feel sleepy after the test. Please make sure you have someone with you who can drive you home afterwards.**

You should allow for about two hours in the hospital.

The staff who will be with you during and after the test are trained to deal with any complications. Please discuss any worries you may have before you agree to the test.

**C. RISKS OF THIS PROCEDURE**

This test involves only a very small risk to you.

These are some of the more serious risks that can happen but are not the only risks:

**5 in 1000 people**

(a) Abnormal heart beat. This may settle without treatment.

**7 in 1000 people**

(b) Abnormally high or low blood pressure. You may need medication to treat this.

(c) Breathing problems. You may need medication to treat this.

**3 in 10000 people**

(d) Tear in the oesophagus. This may settle without treatment.

**2 in 10000 people**

(e) Death

**Most people**

(f) Sore throat for a day or two afterwards.

**D. SIGNIFICANT RISKS AND RELEVANT TREATMENT OPTIONS**

Dr Allada has explained any significant risks and problems specific to me and the likely outcomes if complications occur. He has also explained relevant treatment options as well as the risks of not having the procedure.

PROCEDURAL CONSENT FORM

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**E. PATIENT CONSENT**

I acknowledge that:

Dr Allada has explained my medical condition and the proposed procedure. I understand the risks of the procedure, including the risks that are specific to me, and the likely outcomes.

Dr Allada has explained other relevant treatment options and their risks. He has explained my prognosis and the risks of not having the procedure.

I have been given a Patient Information Sheet which explains the procedure and its risks.

I was able to ask questions and raise concerns with Dr Allada about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.

I understand that a doctor other than Dr Allada may conduct the procedure. I understand this could be a doctor undergoing further training

Dr Allada has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly.

I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements, **I REQUEST TO HAVE THE PROCEDURE.**

Name of Patient/  
Substitute decision maker  
and relationship .....

Signature .....

Date .....

Substitute Decision Maker Under the Powers of Attorney Act 1998 and/ or the Guardianship and Administration Act 2000. If the patient is an adult and unable to give consent, an authorised decision- maker must give consent on the patient's behalf.

**F. INTERPRETER'S STATEMENT**

I have given a translation in .....  
of the consent form and any verbal and  
written information given to the patient/  
substitute decision maker by Dr Allada.

Name of Interpreter .....

Signature .....

Date .....

**G. DR ALLADA'S STATEMENT**

I have explained

- the patient's condition
- the need for treatment
- consequences of not having the treatment
- the procedure and the risks
- relevant treatment options and their risks
- likely consequences if those risks occur
- the significant risks and problems specific to this patient.

I have given the patient/ substitute decision-maker an opportunity to

- ask questions about any of the above matters
- raise any other concerns

which I have answered as fully as possible.

I am of the opinion that the patient/ substitute decision-maker understood the above information.

**Christopher Allada** .....

**Consultant Cardiologist** .....

Signature .....

Date .....