

# CONSENT FOR UPRIGHT TILT TABLE TEST WITH CONTINUOUS BLOOD PRESSURE MONITORING

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE INPT NAME & MRN

## A. CONSENT FOR PROCEDURE

I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

If an exploratory operation is proposed, I have been informed of possible conditions that may be discovered and I consent to performance of procedure(s) as determined by my physician to be in my best interests.

1. I authorise Dr. **Allada**, and such physicians in training and assistants as he may select, to treat my condition, including performing further diagnostic tests and the procedures described below.  
**I UNDERSTAND THAT PHYSICIANS IN TRAINING MAY PERFORM PORTIONS OF THE PROCEDURES DESCRIBED BELOW UNDER THE PARTICIPATORY SUPERVISION OF DR ALLADA.**
2. I understand my condition to be: **Syncope, Loss of consciousness**
3. I understand the proposed procedure(s) to be: **Upright tilt table test with continuous blood pressure monitoring.**
4. I understand the risks associated with the proposed procedure(s) to be: **Loss of consciousness, damage to artery.**
5. I also understand that there may be other RISKS OR COMPLICATIONS, SERIOUS INJURY OR EVEN DEATH from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.
6. I understand the alternatives to the proposed procedures and the related risks to be: **No testing, Medical therapy.**
7. I understand and agree that any tissues or parts removed may be disposed of by the hospital authorities.

**CONTINUED ON NEXT PAGE**

**B. CONSENT FOR ANESTHESIA OR SEDATION**      Not required

1. When local anesthesia and/or sedation is used by Dr Allada, Section A1:

- I consent to the administration of such *local anesthetics* as may be considered necessary by Dr Allada. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.
- I consent to the administration of *sedative medications* by or under the direction of Dr Allada named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

---

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the **Department of Anesthesiology**:

- I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic (“being put to sleep”) and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

**C. PATIENT OR PARENT/LEGAL REPRESENTATIVE CERTIFICATION:**

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

If patient is a minor, incompetent or unable to give consent:

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT OR LEGAL AUTHORIZATION

**D. DR ALLADA ATTESTATION**

I have explained the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. The patient and/or their legal representative has verbally communicated to me that they understand the contents of this form.

\_\_\_\_\_  
Christopher Allada

\_\_\_\_\_  
DATE

**E. INTERPRETER ATTESTATION (when applicable)**

I have provided translation to the person(s) whose signature(s) is affixed above.

\_\_\_\_\_  
SIGNATURE OF INTERPRETER

\_\_\_\_\_  
DATE