INFORMED CONSENT FOR FLUORESCEIN ANGIOGRAPHY

Angiography is a diagnostic procedure in which a rapid sequence of photographs is taken to document the blood circulation of the retina/choroid. The dye is usually injected into a vein in the arm, forearm, or hand.

Since the fluorescein dye is a very bright yellow, the skin may appear jaundiced (yellowish) for a few hours and then the yellow color disappears. The dye is excreted through the kidney causing the urine to be bright yellow for 24-36 hours.

Documented adverse reactions to the dyes which can occur include: fatigue, nausea, vomiting, headache, upset stomach, light-headedness, fainting, hives, and itching.

Rarely, severe allergic reactions (anaphylaxis) or bronchospasm (which causes breathing difficulties) can occur and be life threatening.

The leakage of the fluorescein dye out of the blood vessel at the sight of injection can occur and can be painful; every effort is made to prevent this from occurring.

PATIENT’S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I hereby authorize and direct _______________________________ and/or their designees to perform an angiogram and to provide such additional services as they deem necessary and reasonable. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this procedure for me are significantly different.

I have informed my physician of any allergies to foods, iodine, or medications. I have informed my physician if I have asthma. I have informed my physician if I have had previous adverse experiences with ophthalmic dyes.

Intravenous fluorescein is usually not administered to pregnant or nursing women, although there is no scientific evidence to suggest that it might harm the fetus or nursing babies. I am not pregnant or nursing a baby.

I consent to the use of the above photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or the descriptive text accompanying them.

I have read this consent form. I understand this consent form. My questions, if any, have been answered to my satisfaction.

Patient Signature (or Person Authorized to Sign for Patient) Date

Note: This form is intended as a sample form of the information that you as the surgeon should personally discuss with the patient. Please review and modify to fit your actual practice. Give the patient a copy and send this form to the hospital or surgery center as verification that you have obtained informed consent.