

DISCLOSURE AND CONSENT FOR ECHOCARDIOGRAM WITH DEFINITY™

**TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I, _____ voluntarily request Dr. _____ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to diagnose cardiovascular disease.

I understand that I have been referred for an echocardiogram with or without the use of DEFINITY™, a contrast dye. An echocardiogram is a test in which sound waves are used to produce images of the heart. A **Registered Diagnostic Cardiac Sonographer (RDCS)** technician will perform the test. During the course of the test, the technician may determine that images are suboptimal, and the contrast dye is necessary to improve the imaging results of the study. The technician will follow a physician-approved clinical protocol to inject the contrast dye into an intravenous needle placed in my arm.

I realize that just as there may be risks and hazards in continuing my present condition without further diagnosis and treatment, there are also risks and hazards related to the performance of this diagnostic procedure. I understand that as with any drug or contrast agent use, there are potential risks, including the potential for infection, blood clots in veins and lungs, hemorrhage (bleeding), allergic reactions, and even death. Known side effects that might occur with the use of DEFINITY™ are: back pain, headache, chest pain, itching, rash, flushing, wheezing, difficulty breathing, low blood pressure, dizziness, nausea or a combination of symptoms

I understand that every effort will be made to minimize the risks and/or discomfort by preliminary examination and observations during the test. My heart rate, blood pressure, blood oxygen levels and heart rhythm will be monitored closely during and after the test. Emergency equipment and trained personnel are available to deal with unusual situations that may arise. If I experience any of the above side effects or unusual symptoms, I will inform the technician. I may request to stop the test at any time if I feel uncomfortable continuing. I agree to contact my physician or cardiologist for further evaluation if I experience symptoms after the test.

While testing is an excellent way to diagnose cardiovascular disease, tests are not 100% accurate. I acknowledge that no guarantee has been given to me about the anticipated results of testing.

I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents and the risk and the benefits of this test.

I _____ voluntarily consent to and authorize this test.

Patient Printed Name: _____ Patient Signature _____

Witness Printed Name: _____ Witness Signature _____

DATE: _____ TIME: _____