

# CAROTID ENDARTERECTOMY

*Carotid endarterectomy is a surgical procedure that removes blockage from the carotid arteries, which are blood vessels located in the neck that supply blood to the brain. The purpose of this procedure is to allow blood to flow more freely to the brain.*

Patient's  
Initials

\_\_\_\_\_ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

\_\_\_\_\_ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

\_\_\_\_\_ I understand and accept that the most likely material risks and complications of carotid endarterectomy have been discussed with me and may include but are not limited to:

- *bleeding*
- *blood clots*
- *brain damage*
- *heart attack*
- *heart or breathing difficulties*
- *high blood pressure*
- *hyper fusion syndrome*
- *infection*
- *injury to nerves*
- *low blood pressure*
- *plaque buildup*
- *pulmonary embolism*
- *scarring*
- *seizures*
- *stroke*

\_\_\_\_\_ I understand and accept that there are complications, including the remote risk of death or serious disability that exists with any surgical procedure.

\_\_\_\_\_ I understand and accept the risks of blood transfusion(s) that may be necessary.

\_\_\_\_\_ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.

\_\_\_\_\_ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

\_\_\_\_\_ I have informed the doctor of all my known allergies.

\_\_\_\_\_ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

\_\_\_\_\_ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

\_\_\_\_\_ I am aware and accept that no guarantees about the results of the procedure have been made.

\_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative therapies.

\_\_\_\_\_ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

\_\_\_\_\_ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct \_\_\_\_\_, M.D., with associates or assistants of his or her choice, to perform the procedure of carotid endarterectomy on \_\_\_\_\_

at \_\_\_\_\_.

(patient name)

(Facility name)

Continued

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
Physician Signature/Date/Time

\_\_\_\_\_  
initial      copy given to patient

\_\_\_\_\_  
initial      original placed in chart

SAMPLE