YAKIN DOĞU ÜNİVERSİTESİ
HASTANESİ

INFORMED CONSENT FORM FOR INTRAVENOUS THROMBOLYTIC THERAPY

Patient Name-Surname:	**Sex:** □ **F** □ **M**
Patient No:	**Date of Birth:**
Father's Name:	**ID Card No:**

Dear Patient / Guardian,

Having information about recommended all processes aimed at medical/surgical treatment and diagnosis for your general medical condition and treatment is your incontestable right. Consenting to the process is your own choice after learning potential risks and benefits of medical treatment and surgical interventions.

Purpose of this explanation is to raise awareness of taken decisions about your health , not to worry or make you anxious. In case of your request , all informations and documents about your health can be given to you or your relative.

This form is prepared to inform you about the procedure of the test(s) and the potential risks that may arise. Please sign this informed consent form after reading it fully and carefully and all your hesitations are resolved by your doctor.

1. PRE-DIAGNOSIS/DIAGNOSIS:

GENERAL INFORMATION ABOUT YOUR DISEASE:

2. SUGGESTED TREATMENT: Intravenous thrombolytic therapy; rtPA (ACTILYSE)

3. IF SIDE APPLICATION;

Right □ Left □ Two sided □ Level:.....

4. ANAESTHESIA WILL BE: Not used □ Used □

Patient has been informed that anaesthesia is going to be applied for the required intervention and he/she has to consent this application.

5. BLOOD AND BLOOD PRODUCTS USAGE: Not used □ Used □

Patient has been informed if blood and blood products are going to be used for the required intervention and he/she has to consent this application.

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6. RISKS OF SUGGESTEDTREATMENT: There is a risk of hemorrhage in brain or any other part ofbody that worsening the condition about %6.

7. FORESEEN POTENTIAL BENEFITS OF SUGGESTED TREATMENT

Paralysis is developed due to stenosis in brain arteries. Consequently with the aim of reduce the risk of death or serious disability and recover, rt PA (ACTILYSE) medicine is applied for early stage appropriate patients with intravenous thrombolytic therapy to remove the stenosis. With this application as distinct from other treatment methods, it is tried to dissolve the thrombus, the damage in bloodless part of brain minimized and recover with minimum loss is provided.

8. SUCCESS PROBABILITY OF SUGGESTED TREATMENT:

The recovery chance with thrombolytic rt-PA-Actilyse is about %30.

9. POSSIBLE ALTERNATIVE TREATMENT(S)

There is not any alternative treatment medically. For the selected patients there are treatment methods that clear occluded artery with angiographic methods.

10. THINGS TO TAKE INTO CONSIDERATION FOR CONVALESCENT: Under physician control, the patient should be followed in intensive care unit for early determination of possible complications.

11. POTENTIAL RESULTS OF REJECTING SUGGESTED TREATMENT: Paralysis is developed due to stenosis in brain arteries. Consequently, depending upon size of influenced artery, potential death or serious disability (arm and leg weakness) risk, visual and talk impairment may developed and it can be a permanent damage.

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EXTEND AND CONSENT OF THE SUGGESTED INTERVENTION

✓ I have been informed orally about the details of the suggested treatment by my physician, I have read the information prepared for the procedures. I have been asnwered sufficiently where I required explanation.

✓ I consent all interventions done in emergency and unexpected situations.

✓ My physician gave information that addtional medical application required conditions depending upon foreseen and unforeseen situations may arise. I understood and approved that additional interventions except the stated ones in this form will apply for only prevent health problems and save my life if necessary.

✓ Medical device usage like rontgen, fluoroscopy, ultrasonography, scintigraphy, CT and magnetic resonance may required; I know that I may exposed to harmful rays in some of these devices/applications

✓ I have been informed about approximate cost of the intervention.

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Taking full account of my right of objection , I warrant and approved scientific purposed examination, preservation , use and dissolve of my removed tissue/organ or tissue/cell cultures and imaging of these during the treatment.

I ……....., have understood the content of this form.I consciously accept the treatment that will be done to me at Near East University Hospital. I accept all medications , examinations and interventions to perform for my disease treatment.

Signature: Date: Hour:

In case signed by Legal Guardian;

How is the Legal Guardian related to the Patient:

□ Patient is unconscious □ Emergency □ Patient is not authorized to make decision

□ Patient is younger than 18 years

In case signed by Legal Guardian;

How is the Legal Guardian related to the Patient:

□ Patient is unconscious □ Emergency □ Patient is not authorized to make decision

□ Patient is younger than 18 years

Witness(Not a hospital staff,if presen ;

Name-Surname: Signature: Date: Time:

Informing Doctor;

Name-Surname: Signature: Date:

Time:

Translator (If needed);

Name-Surname:Time: Signature: Date:

- Patients older than 18 years by themselves,
- Patients between 15-18 years both by themselves and by their Legal Guardian,
- Unconscious Patients, Patients younger than 15 years, Patients that are not authorized to make

decision and at Medical Emergencies by their Legal Guardian.

- “SHOULD CONSENT AND SIGN THIS FORM”