Gleneagles Hospital
HONG KONG
港怡醫院

Consent for Intravascular Contrast Computerized Tomography

For Clinic Use	For RTO Use
Please fill in or affix patient label	*Please fill in or affix patient label*
Name : M / F	Name : M / F
HKID No. : DOB :	HKID No. : DOB :
Contact No. :	Contact No. :

RADIOTHERAPY AND ONCOLOGY CENTRE

A. Person(s) Signing This Form (The Signatory)

The Patient is named in the right hand top corner of this Form.
The signatory signing this Form is/are: (Please tick "✓" as appropriate.)

- ❑ the patient.
- ❑ the parent or guardian of the patient who is a minor (age under 18).
- ❑ the patient's legal guardian appointed under Mental Health Ordinance (MHO) with power to consent to the proposed procedure / treatment.

Details of the ❑ parent / ❑ guardian / ❑ legal guardian appointed under MHO

_____ _____
Full Name(s)of Parent or Guardian ❑ HKID Card / ❑ Identity Document No of Parent or Guardian

B. Explanation of The Nature and Effect / Benefits Of The Procedure / Treatment

The doctor / health professional, who signs this Form, has explained the nature and effect / benefits of the procedure / treatment to the Patient and/or Patient's parent or guardian/ the Patient's legal guardian appointed under MHO as set out below:

1. The Patient's diagnosis / indications for the procedure / treatment: Not Applicable
2. Name and nature of the procedure / treatment for the Patient:
   Intravascular Contrast Computerized Tomography
   Site: ❑ Head / Neck ❑Thorax ❑ Abdomen ❑ Pelvis
   ❑ Upper Limb ❑ Lower Limb ❑ Spine ❑ Others: _____
3. The intended effect / benefits of the procedure / treatment for the Patient:
   For Radiotherapy Planning

C. The Risks and Complications / Side Effect Associated With The Procedure / Treatment

Iodinated contrast media are commonly used in radiological investigations. They are generally safe although adverse reactions are occasionally encountered following contrast medium injection:

- **Mild reactions** – Mild reactions are self-limited and usually no medical management is required. These mild reactions include limited urticaria / itchiness, nausea, vomiting, sneezing, coughing, feeling of warmth, conjunctivitis, rhinorrhea, etc.
- **Moderate reactions** – Moderate reactions are more pronounced and medical management is commonly required. Some of these reactions can potentially progress to severe reactions if not treated. These moderate reactions include diffuse urticaria / itchiness, facial oedema, throat tightness or hoarseness without short of breath, mild wheezing, chest pain, abnormal blood pressure, etc.
- **Severe reactions** – **1.** Severe reactions are often life-threatening and can result in permanent morbidity or death if not promptly treated. These severe reactions include difficulty in breathing caused by diffuse, facial or laryngeal oedema, and bronchospasm; severe hypotension or hypertension, irregular heartbeats, convulsions, etc. **2.** Overall acute adverse reaction rate has been reported as 0.7% while incidence of serious acute reactions has been reported as four in 10,000. Death related to administration of intravascular iodinated contrast media has been reported as 2.1 fatalities in a million studies. Nearly all life-threatening contrast reactions occur within the first 20 minutes after contrast medium injection.
- **Delayed adverse reactions** – Delayed adverse reactions may occur from one hour to up to one week following contrast medium injection. These are commonly skin reactions and include urticarial, rash and itchiness. Rare delayed reactions include iodide "mumps" and acute joint pain.
- **Contrast Extravasation** – Extravasation of contrast media is a potential complication that has an overall incidence of less than 1% and is due to leakage of contrast media to soft tissue adjacent to the injection site. Extravasation of small amount of contrast media may result in swelling and/or pain, and is commonly self-limited. More severe injuries may result in skin ulceration, tissue necrosis and compartment syndromes.
- **Lactic Acidosis** – Diabetic patients taking Metformin have the potential risk of developing lactic acidosis following contrast medium injection, in particular in patients with impaired renal functions. Reported incidence is less than 8.4 cases per 100,000 patient years. Patient mortality in reported cases is about 50%.

❑ Effects / risks associated with the procedure / treatment to the Cardiovascular Implantable Electronic Devices. (Refer to Information Sheet:_____)

D. The Risks / Complications For The Option Of No Treatment: Not applicable

E. Any Consequential Procedure(s) Which May Become Necessary During / Following The Procedure / Treatment (If applicable) : _____

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F. Any Additional Treatment That Requires Prior Consent From The Patient Before Proceeding The Procedure (If applicable) : _____

G. Information Sheet (Please tick "✓" if applicable)

❑ I / We confirm that I / we have been provided with an information sheet on the procedure / treatment (_____), that I / we have reviewed and fully understand the contents.

H. Consent to The Procedure / Treatment

I / We, the undersigned Patient and /or Patient's parent or guardian/Patient's legal guardian appointed under the MHO:

1. consent to undergo / consent to the Patient undergoing the procedure / treatment set out above. The doctor / health professional(s) (who signs this Form) has fully explained the nature, effects, benefits, general / specific risks and complications / side effect of procedure / treatment, to me / us which I / we fully understand.
2. understand other treatment options and their associated outcomes and risks. The doctor / health professional(s) (who signs this Form) has answered any questions and enquiries raised by me / us which I / we fully understand.
3. consent to undergo / consent to the Patient undergoing such alternative or further procedures / treatment that the doctor(s) / health professional(s) may consider necessary or desirable.
4. understand that although the doctor(s) / health professional(s) will perform the procedure / treatment in the Patient's best interest, there is no guarantee of cure or improvement. Fully aware that the radiotherapy treatment is only delivered to targeted area, chances of disease progression, metastasis and/or recurrence may occur during or after the treatment.
5. understand the possible outcomes of **NOT** having the procedure / treatment. Aware that the procedure / treatment may be terminated as a result of disease progress or physical conditions of the undersigned Patient.
6. consent to undergo / consent to the Patient undergoing such tests and examinations that the doctor(s) / health professional(s) may consider necessary or desirable.
7. consent to / consent to the Patient authorize health professional(s) to take photographs of the treatment area for documentation. Understand the photographs or video recording may be taken for medical record keeping / teaching or research purpose.
8. understand that no assurance can be given by the hospital that the procedure / treatment, will be performed by particular doctor(s) / health professional(s). The doctors(s) / radiation therapist(s) who will perform the procedure / treatment will, however, be suitably qualified.
9. understand the described / said complications and risks of the procedure / treatment are not exhaustive. Rare complications may not be listed.
10. fully informed of the charges on such procedure / treatment and that extra fees shall be incurred if additional procedure / treatment considered necessary or desirable.
11. **For female patient only**: **I/We hereby confirm that I/the Patient undergoing the procedure/treatment am/is not pregnant and shall be responsible for all consequence should I/the Patient be found pregnant at the time of procedure/treatment.**
12. agree that this consent shall remain valid for 180 days from the date it was signed or the duration of one hospital admission even though the above procedure / treatment may be re-scheduled from time to time.
13. understand that, if I / we have any further questions, I / we can ask the doctor / health professional(s); and I / we have the right to withdraw my /our consent at any time after I / we have signed this form.

Signature(s) of Signatory(s)	Signature of Doctor / Health Professional	Signature of Witness (if applicable)
Full Name(s) of Signatory(s)	Full Name of Doctor/ Health Professional	Full Name of Witness (if applicable)
Date	Date	Date (if applicable)

This Part To Be Completed By Interpreter *(Please fill in the below information if applicable)*

I _____ , _____certify that I have truly, distinctly and audibly
Full Name of Interpreter *HKID Card / Identity Document No.*

interpreted the consent of this document into _____ to the signatory.
Language / Dialect Used

Signature of Interpreter : _____ Date: _____

Note: The witness, if available, should be involved in the whole process, from explanation to signing of this Form.