I hereby give my consent and authorize

______________________________

(The list of possible assistants, all of whom are credentialed to provide surgical services at the hospital, is available)

to treat the following conditions:

Dizziness, syncope or fainting.

by performing the following procedure(s):

The heart rate and rhythm, blood pressure and other vital signs will be monitored and the head of the table tilted up in the air to try to duplicate the symptoms you have experienced. The tilt may be repeated after medications.

1. The care provider has explained my condition to me, the benefits of having the above treatment procedure, and alternate ways of treating my condition. I understand that no guarantees have been made to me about the result of the treatment. The alternatives to this procedure include:

   Not performing the procedure.

2. The care provider has discussed with me the reasonably foreseeable risks of the treatment and that there may be undesirable results. The risks that are specifically related to this procedure include:

   Bleeding or bruising at the intravenous site; nausea or vomiting; stroke; myocardial infarction; or death.

3. I understand that during the treatment a condition may be discovered which was not known about before the treatment started. Therefore, I authorize the care provider to perform any additional or different treatment which is thought necessary and available.

4. I consent to the administration of local, regional or general anesthesia and/or sedation as deemed most appropriate for the procedure to be performed. (The list of possible anesthesia providers, all of whom are credentialed to provide anesthesia at this hospital, is available).

5. Any tissue, parts, or substances removed during the procedure may be retained or disposed of in accordance with customary scientific, educational and clinical practice.

6. At the discretion of the doctor I consent to the presence of manufacturer’s representatives to aid in the service and correct calibration of the correct instrumentation. I understand that at no time will these representatives actively participate in my procedure.

(continued on back)
CONSENT FOR
TILT TABLE TESTING
SH 419TTT MR
Page 2 of 2

Patient Name: ___________________________ DOB: __________

7. Patient Consent for Medical or Surgical Procedure: I have carefully read and fully understand this informed consent form, and have had sufficient opportunity to discuss my condition and the above procedure(s) with the care provider and his/her associates, and all of my questions have been answered to my satisfaction.

Signature of Patient ________________________
Date _______ Time ______

Signature of Parent or Legal Guardian (if Patient is unable to sign or is a minor)

Relationship to the Patient ________________________

Complete this section for all OR procedures and all other invasive internal procedures performed in any setting. If items 8-10 are not applicable for this case, proceed to Attestation below.

8. Consent for Receipt of Tissue(s):
   ☐ yes (please list), ________________________________
   ☐ not expected to be needed, but may be required and given in an emergency
   ☐ refused

9. Consent for Blood Transfusion:
   ☐ yes
   ☐ not expected to be needed, but may be required and given in an emergency
   ☐ refused. Refer to SMH Policy 9.18 (Refusal of Blood (or Blood Products) Transfusions or HH Policy 4.1 (Blood Transfusion-Refusal to Permit).

For those procedures that have the potential for significant blood loss, I consent to the transfusion of blood or blood components that may be necessary before, during or after the procedure. I have been informed that no transfusion is 100% safe, however present testing methods make the risks of infection very small. Risks include infection from viruses, bacteria, or parasites, including but not limited to HIV (the AIDS virus) and hepatitis, as well as fever, chills, allergy, volume overload, or death. I have discussed possible alternatives with my care provider, including no transfusion, autologous transfusion (donation of my own blood), designated/directed donor transfusion (collection of blood from donors selected by me) or blood salvage during the procedure. I understand that these alternatives may not be available due to timing or health reasons, and the above risks may still apply.

10. Patient Consent for Blood/Tissue: I have had a chance to discuss the risks, benefits and alternatives regarding transfusion/receipt of tissue (as above) with my healthcare provider. My decision(s) regarding the transfusion of blood or blood components and/or the receipt of tissue are as above. I understand this covers my perioperative/periprocedural (before, during, and after the surgery/procedure) course of treatment.

Signature of Patient ________________________
Date _______ Time ______

Signature of Parent or Legal Guardian (if Patient is unable to sign or is a minor)

Relationship to the Patient ________________________

ATTESTATION

I have discussed the planned procedure, including the potential for any transfusion of blood products or receipt of tissue as necessary, expected benefits, the potential complications and risks and possible alternatives and their benefits and risks with the patient or the patient’s surrogate. In my opinion, the patient or the patient’s surrogate understands the proposed procedure, its risks, benefits, and alternatives.

Signature of Care Provider ________________________
Date _______ Time ______

Printed name and title ________________________