CONSENT FOR ADMINISTRATION OF tPA FOR ACUTE ISCHEMIC STROKE

The form on the next page can serve as a guide for a standardized consent for TPA for acute ischemic stroke. You may modify this form to best meet your needs. We recommend your hospital's legal team review this form before implementation.

In addition to this consent form, we recommend that the patient also receive more detailed supporting material such as "Informed Consent – TPA in Ischemic Stroke" which is available in the Emergency Excellence ED Toolkit at:
http://www.emergencyexcellence.com/ed_toolkit/tPA%20in%20Ischemic%20Stroke.pdf

CONSENT FOR ADMINISTRATION OF tPA FOR ACUTE ISCHEMIC STROKE

Date:_____ Time: _____

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

1. I authorize Dr._____ and such assistants as may be chosen by him/her to perform the following treatment: **Intravenous tPA, which is a thrombolytic ("clot-busting") therapy for stroke**

2. **Risks and Complications:** I understand that any treatment can be associated with risks and complication that can include allergic reactions, bleeding, adverse effects of drugs, loss of bodily functions, failure to relieve symptoms. The physician/practitioner has informed me that the particular risks and complications associated with the recommended operation(s), treatment and/or procedure(s) include, but are not limited to: **Death, permanent disability, intracranial hemorrhage or other life-threatening bleeding**

3. **Benefits of Procedure:** I have been informed of the following benefits of having such treatment performed: **Possible improvement of acute stroke symptoms**
4. **Alternative Treatments:** I have been informed of the following alternatives of care if this procedure(s) is not performed: **Conservative management / supportive care**
5. **Risks and Complications of Alternative Treatments: Will not receive possible benefits of thrombolytic therapy**

6. **Unforeseen Conditions:** Realizing that it is impossible for any physician to foresee all possible conditions and inform me of the same, I hereby authorize and request the physician and other necessary persons to provide additional operations, treatments or perform additional procedures for any conditions discovered during the performance of the procedure consented to in paragraph 1 that the physician deems necessary in the exercise of his/her professional judgment.

7. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this treatment.

I have read and I understand the entire document and I voluntarily consent to the treatment as explained to me by my physician. I am aware that I am free to withdraw my consent at any time prior to the performance of the treatment

_____ _____

Witness to Signature Signature of Patient/Legal Representative

Relationship:_____

I acknowledge that I have personally explained the above information to the patient or his/her representative.

_____

Physician Signature