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INFORMED CONSENT FOR FLUORESCEIN and/or INDOCYANINE GREEN ANGIOGRAPHY (ICG)

PATIENT NAME: _____

Your consent must be obtained before any contemplated medical or surgical procedure. You are being asked to sign this form to confirm that the procedure and its risks, with respect to your condition, have been discussed with you; that you have been given sufficient information to make a decision; and that you have made all choices of your free will. The information in this form is intended as a summary of the information provided by your physician or by a member of RETINA ASSOCIATES.

1. I hereby give my consent and authorize any of the physicians of RETINA ASSOCIATES, who are identified above, to administer intravenous fluorescein and to perform fluorescein angiography, individually or through technicians employed by RETINA ASSOCIATES.
2. Fluorescein/ICG angiography is a diagnostic procedure that photographs the blood circulation of the retina. The fluorescein/ICG dye is usually injected into a vein in the arm or hand.
3. I understand that, because fluorescein dye is a very bright yellow, I may notice a yellow tint to my skin for 6 to 12 hours after the injection. I also understand that, because fluorescein dye is excreted by the urinary system, my urine will be yellow-orange for 24 to 36 hours after the injection.
4. Indocyanine green is excreted through the bile and will show in the stool as greenish. The coloration of these dyes are considered to be a normal result of the after effects.
5. Adverse reactions to the dye are uncommon but may include the following: nausea, headache, upset stomach, vomiting, light-headedness, fainting, hives, and extravasations (leakage of dye out of the blood vessel). Serious adverse reactions such as the following are extremely rare but have been reported in the medical literature: cardiac arrest, basilar artery ischemia, shock, convulsions, bronchospasms, thrombophlebitis and death.

FOR WOMEN: Intravenous dye is not usually administered to pregnant women, although there is no scientific evidence to suggest that it might harm babies before they are born.

6. I understand that there is no alternative procedure that will provide the same information.
7. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee has been made to me concerning the results that may be obtained.
8. I consent to the admittance of observers, the use of closed-circuit television, the taking of photographs (including motion pictures), and the preparation of drawings and similar illustrative graphic material and I also consent to the use of such photographs and other materials for scientific purposes, providing that my identity is not revealed by the pictures or by the descriptive text accompanying them.
9. I acknowledge that I have read this document in its entirety, that I fully understand it, and that all spaces have been completed or crossed off prior to my signing. I further acknowledge that the disclosure of the foregoing information has been made to me and that all my questions have been answered satisfactorily. I understand that by signing this consent form I do not waive any of my legal rights. My signature does not relieve the doctor or staff of liability; it merely indicates that I have been informed about the risks of the procedure to which I am consenting.

Patient's Signature

Date

Witness's Signature

Date

Signature of Parent, Legal Guardian or Representative, or Next of Kin

Date

FLUORESCEIN/ICG ANGIOGRAPHY SUBSEQUENT CONSENT

Patient's Signature

Date

Tech Initials

Patient's Signature

Date

Tech Initials

Patient's Signature

Date

Tech Initials

Patient's Signature

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Tech Initials

Patient's Signature

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