INFORMED CONSENT FOR FLUORESCEIN ANGIOGRAPHY

Patient:____

Angiography is a diagnostic procedure in which a rapid sequence of photographs is taken to document the blood circulation of the retina/choroid. The dye is usually injected into a vein in the arm, forearm, or hand.

Since the fluorescein dye is a very bright yellow, the skin may appear jaundiced (yellowish) for a few hours and then the yellow color disappears. The dye is excreted through the kidney causing the urine to be bright yellow for 24-36 hours.

Documented adverse reactions to the dyes which can occur include: fatigue, nausea, vomiting, headache, upset stomach, light-headedness, fainting, hives, and itching.

Rarely, severe allergic reactions (anaphylaxis) or bronchospasm (which causes breathing difficulties) can occur and be life threatening**.**

The leakage of the fluorescein dye out of the blood vessel at the sight of injection can occur and can be painful; every effort is made to prevent this from occurring.

PATIENT'S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I hereby authorize and direct The Mount Ogden & Bountiful Hills Eye Centers and/or their designees to perform angiography and to provide such additional services as they may deem necessary and reasonable. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this procedure for me are significantly different.

I have informed my physician of any allergies to foods, iodine, or medications. I have informed my physician if I have asthma. I have informed my physician if I have had previous adverse experiences with ophthalmic dyes.

Intravenous fluorescein is usually not administered to pregnant or nursing women, although there is no scientific evidence to suggest that it might harm the fetus or nursing babies. I am not pregnant or nursing a baby.

I consent to the use of the above photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or the descriptive text accompanying them.

I have read this consent form. I understand this consent form. My questions, if any, have been answered to my satisfaction.

__________________________________ ____________________

Patient's Signature Date