Eastern Heart Clinic

Patient identification label

RADIOFREQUENCY CATHETER ABLATION (RFA) CONSENT

PLEASE READ THE FOLLOWING INFORMATION

You have been referred for a Radiofrequency Catheter Ablation (RFA) because you may be experiencing abnormal electrical impulses through your heart causing it to beat too fast or too irregularly. Your doctor has determined the cause of the abnormal electrical pathway in your heart and has recommended that you have a RFA.

RFA is a treatment that disrupts the pathway and prevents the abnormal heart rhythm. RFA is the delivery of radiofrequency energy to the area of the heart that is causing the abnormal heart rhythm to create scar tissue in the area and disrupt the abnormal pathway.

RFA may be undertaken using either sedation or an anaesthetic, you will be advised of this by your Doctor. Your Doctor inserts small tubes in your groin (once anaesthetised) and passes a specialised ablation catheter through the tube and onto the specific location in the heart that requires ablating.

There are certain risks about this procedure, of which you will need to be informed. There is a (1 in 2000) chance of death, heart attack or stroke. A (1 in 200 - 500) chance for the need of a pacemaker. A (1-2 in 100) chance of bleeding, infection, blood clot and nerve or vessel damage. If the risks are substantially different from the above, the doctor will list this here.

These procedural risks will vary between individuals and depend on pre-exsting risk factors and medical conditions so please discuss these issues with your Doctor if you are concerned. Your Cardiologist believes that the benefit of the procedure outweighs the risks outlined.

For this procedure we may have supplier representatives present to assist during the procedure.

CONSENT

I have read the above information and had the opportunity to ask questions and I am happy with the response. I hereby give my consent to undergo a Radiofrequency Catheter Ablation (RFA).

Patient / Guardian: ______________________ ______________________ ____/____/____
Signature Print Name Date

Doctor: ______________________ ______________________
Signature Print Name

Interpreter: ______________________ ______________________
Signature Print Name

FURTHER PATIENT DECLARATION

I have received a copy of the “Outcome Data Information Sheet” and I have read and understood my Rights and Responsibilities.

Patient / Guardian: ______________________ ______________________
Signature Print Name