DIRECTORATE OF HEALTH SERVICES KASHMIR

PATIENT INFORMED CONSENT FORM FOR THROMBOLYTIC THERAPY IN ACUTE MYOCARDIAL INFARCTION

1. PURPOSE AND BENEFITS:

Heart attacks are usually due to blood clots in one or more arteries in the heart, which stop the supply of oxygen rich blood to the heart muscle. The blockage causes pain and can result in permanent damage to the heart. The purpose of this treatment is to obtain the benefit of a clot-dissolving drug, Streptokinase (STK). It is anticipated that this therapy will reduce the extent of heart muscle damage if it is initiated soon enough after the beginning of symptoms.

CHECKLIST OF ABSOLUTE CONTRAINDICATIONS:

a.	**PRIOR ICH**	**YES / NO**
b.	**ANY AV MALFORMATION**	**YES / NO**
c.	**INTRACRANIAL NEOPLASM**	**YES / NO**
d.	**ISCHEMIC STROKE IN LAST 3 MONTHS**	**YES / NO**
e.	**AORTIC DISSECTION**	**YES / NO**
f.	**ACTIVE BLEED/BLEEDING DISORDER**	**YES / NO**
g.	**HEAD TRAUMA IN 3 MONTHS**	**YES / NO**
h.	**CRANIAL/SPINAL SURGERY IN 2 MONTHS**	**YES / NO**
i.	**SEVERE UNCONTROLLED HYPERTENSION**	**YES / NO**
j.	**PRIOR STPASE THERAPY IN LAST 6 MONTHS**	**YES / NO**

2. RISKS AND DISCOMFORTS:

STREPTOKINASE (STK), THE CLOT DISSOLVING DRUG, CAN CAUSE THE FOLLOWING SIDE EFFECTS:
ABNORMAL BLEEDING IN A SMALL PERCENTAGE OF PATIENTS, IRREGULAR HEART RHYTHMS, LOW BLOOD PRESSURE, ALLERGIES INCLUDING ANAPHYLAXIS, OTHER SIDE EFFECTS INCLUDING DEATH.

3. I authorize Dr._____to administer this drug for my treatment.

4. I understand that no guarantee or assurance has been made as to the results of the procedure and I understand that there is a chance it may not cure the condition.

5. I consent to any photographing or videotaping of the procedure provided my identity is not revealed by the pictures or by descriptive texts accompanying them for academic purpose and follow up.

6. I certify that I have read this form/ have had it read to me. I understand this information and have no further questions.

- **Patient signature: _____**

Authorized relative Name and signature: _____

- **Witness (Name and Signature): _____**

- **Treating Doctor's declaration:** I have discussed the contents of this form with the patient and have answered all of the patient's questions regarding the treatment.

Doctor's Signature:_____ TIME AND DATE--_____