



Central Family
Practice

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Stroke/Vascular Screening Patient Consent Form

Consent to Vascular Screening

I voluntarily request a vascular screening study. I understand that this procedure involves vascular imaging technology. I understand that a vascular screening may not be sufficient for diagnosis purposes and that an additional procedure may be required in the event that an abnormal finding is made on the vascular screening.

The vascular screening is being conducted by Central Family Practice, and will be performed by a registered vascular technologist (RVT) employed by B.B. Imaging, and abnormal results will be reviewed with a physician. The vascular screening is a noninvasive procedure and requires no special preparation. During the test, the sonographer will image the carotid arteries, abdominal aorta, and peripheral arteries using a small probe or transducer with a small amount of gel placed on the skin. Patients should dress comfortably wearing a collarless shirt and lose clothing (no sweaters or hose please) which allows easy access to the arms, ankles, and abdominal region.

The screening will take approximately 20 minutes to complete.

No Warranty or Guarantee

I understand that no warranty or guarantee has been made to me as to the results of the vascular screening. I understand that this test screens for only carotid artery stenosis, abdominal aneurysm, and peripheral arterial disease. A normal screening does not rule out all vascular disease.

Communication of Results To Primary Physician (if other than Central Family Practice)

A copy of the test results will be made available to you immediately after completion of the screening. *Should the results show a potential abnormality*, they will be forwarded to your family physician for further review.

Should there be a potential abnormality, I request a copy of the screening results be forwarded to my **primary care physician** at the following number (fill out if Central Family Practice is not your primary care facility):

Primary Physician's Name: _____ **Ph:** _____ **Fax** _____

Personal Commitment to Follow-up Results

I recognize and acknowledge that I am personally responsible for taking appropriate follow-up action upon receipt of screening results. I understand and acknowledge that it is my responsibility to decide whether to take this action and pursue medically-indicated care and treatment. I understand that follow-up care and treatment is not a part of this screening and that I am financially responsible for the cost of any and all follow-up care, treatment, and/or procedures whether or not covered by my insurance.

PLEASE CAREFULLY READ AND ACKNOWLEDGE YOUR UNDERSTANDING OF THE FOLLOWING IMPORTANT INFORMATION RELATING TO YOUR LEGAL RIGHTS UNDER THIS VASCULAR SCREENING PROGRAM.

Release of Claims

I, on behalf of myself and my representatives, executors, and administrators, do hereby absolutely, fully and forever release, waive, and relinquish Central Family Practice, physician and their respective agents, employees, representatives, trustees, administrators, , partners, principals, officers, and directors, and of each of them, of and from all actions or causes of action, actual or alleged claims, judgments, demands, debts, losses, obligations, liabilities, cost expenses, sums of money, damages, and/or liens for any kind of undiscovered, accrued or uncured, suspected or unsuspected, which either party may now have claim to have, or which may involve or related to the performance, interpretations, and communication of the results of the vascular screening.

Waiver

I understand and agree that the Release set forth above is intended to be a full general release of all claims of every kind whatsoever, known or unknown, discovered or undiscovered, suspected or unsuspected, arising out of, in connection with, in consequences of, in any way involving or related to the performance, interpretation, and communication of results of the Vascular Screening. I understand and acknowledge that I am expressly waiving my rights under state and federal laws to the full extent that I may lawfully waive all sick rights and benefits pertaining to the subject matter hereof.

Acknowledgment

I certify that I have read this form or have had it read to me, that the blank spaces have been filled in, and I understand its content.

_____	_____	_____
Patient's Signature	Printed Name	Date

You were screened by sonography and vascular technology for the following:

Carotid Stenosis (possibly >50%)	_____	Absent	_____	Present
Abdominal Aortic Aneurysm	_____	Absent	_____	Present
Peripheral Arterial Disease	_____	Absent	_____	Present

“Present”; only represents the presence of disease and should trigger a full exam to determine actual severity. If any of the above is present, you should contact your primary care provider.

_____	_____
Krista London, RDMS, RVT	Date