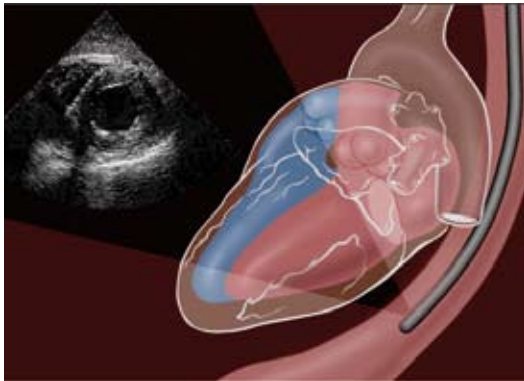


WHAT IS IT?

Transoesophageal echocardiography (TOE) uses sound waves to produce images of the heart. Unlike standard echocardiography, TOE uses a tube-like device placed in the mouth and passed down the throat into the oesophagus (the food pipe that connects the throat to the stomach) to record images of the heart.

This test shows our Cardiologists the size, shape and movement of your heart muscle and valves. Examination of large blood vessels such as the aorta (the main blood vessel supplying blood to your body) also occurs during this procedure.



▲ The TOE probe, when placed in the food pipe, can capture high quality pictures of the heart.

PREPARATION

Do not eat or drink anything for 6 hours before your test. If you have diabetes, you should talk to your Cardiologist about food and insulin intake because these can affect your blood sugar levels.

WHAT SHOULD I EXPECT?

The procedure typically takes no longer than 20 minutes. At the beginning of the procedure, the Cardiologist numbs your throat with an anaesthetic spray.

The Cardiologist then places a needle connected to a tube (called an intravenous line or 'IV') into an arm vein. Sedation given through this IV helps you relax throughout the test and most people fall asleep.

Next, the Cardiologist passes the small flexible TOE probe into your throat. You are then asked to swallow and the probe gently moves down your throat into your oesophagus.

When in place, you should not feel any pain from this probe. On the end of the probe is the ultrasound camera which takes pictures of your heart from different angles.

Removal of the probe and IV line occurs when all the required pictures are taken. You may feel sleepy until the sedative has worn off. Monitoring of your heart rate and blood pressure occurs during this recovery period.

You may find that you have a sore throat or trouble swallowing after the procedure, however, these side effects usually subside after a day. Occasionally, you are required to stay in hospital overnight.

The Cardiologist analyses the images and sends the report to your referring doctor, usually on the same day.

By law, you must not drive a motor vehicle or operate machinery within 12 hours of this procedure. Therefore, you will need to organize transport home and a responsible adult should stay with you during the rest of the day.

You should read the consent form (over page) and understand the risks involved with this procedure. Please clarify any concerns or queries about this procedure with your Cardiologist before signing this form on the day of the procedure.

TESTING

WESLEY HOSPITAL
3rd Floor
Wesley Private Hospital
Chasely Street
Auchenflower QLD 4066
† (07) 3870 4144
f (07) 3870 8481

MOUNT OMMANEY
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Medical Centre
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Mt Ommaney QLD 4074
† (07) 3279 4111
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Figtrees
Suite 3 1st Floor
531 Sandgate Road
Clayfield QLD 4011
† (07) 3262 7477
f (07) 3262 9631

GREENSLOPES
Suite 6
Greenslopes Specialist Suites
Newdegate Street
Greenslopes QLD 4120
† (07) 3394 3100
f (07) 3394 3118

CONSULTING

BRISBANE METROPOLITAN
Wesley
Clayfield
Mount Ommaney
Green Slopes

QUEENSLAND
Hervey Bay
Kingaroy
Maryborough
Rockhampton
Roma
Beaudesert
Emerald
Gladstone
Gympie
Ipswich

Name	Date of Birth	Medical Record Number
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I, Dr _____

Have discussed with the Patient/Parent/Guardian,

Patient's name _____

the patient's present condition, alternative treatments available and have explained the risks of

TRANSOESOPHAGEAL ECHOCARDIOGRAPHY

Which may include:

- 1/7,000 risk of Oesophageal (food pipe) damage, which may require surgery
- Potential damage of teeth/fillings/dental prosthetics
- 1/10,000 risk of death

Medical Doctor's signature _____

I, _____

of _____

request TRANSOESOPHAGEAL ECHOCARDIOGRAPHY to be performed on me/upon

I also request the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this procedure.

I understand that other unexpected operation/procedures may be necessary and I request that these be carried out if required.

I understand that a sample of blood may be need to be tested, if there is any injury to either my doctor or a hospital staff member during the procedure.

Although this procedure will be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this procedure.

I have had the opportunity to ask questions about the procedure and I am satisfied with the information I have received.

Signature of Patient/Parent/Guardian/Other (specify below)

Signature of Witness to Patient's Signature

Specify Other (Print)

Full Name of Witness (Print)

Address of Witness

Special Provisions (if applicable)

Date