SEMMELWEIS UNIVERSITY
Faculty of Medicine
Department of Pulmonology

Head of the Department
Prof. Veronika Müller M.D., Ph.D., D.Sc

SEMMELWEIS UNIVERSITY
Faculty of Medicine
Department of Pulmonology

Prof. Dr. Veronika Müller, University Professor, Head of the Department

ELECTRICAL CARDIOVERSION – MEDICAL PROCEDURE

INFORMED CONSENT FORM

This is an English translation of the original Hungarian patient information and consent form.

Document Version: 1.0 – Date: 2026-03-16

Address: H-1083 Budapest, Tömő street 25-29. HUNGARY
Postal address: 1428 Budapest Pf. 2.
E-mail: titkarsag.pulm@semmelweis.hu
Tel.: (+36-1) 459-1500
semmelweis.hu

INTERVENTION: ELECTRICAL CARDIOVERSION

Patient's name: .....
Patient TAJ number (Social Security Number): .....
Legal representative/Patient representative: .....
Informing physician: .....

I have been informed that because of a cardiac arrhythmia, electrical cardioversion has been recommended to restore my heart's normal rhythm.
The procedure is performed under brief general anesthesia, induced by a short-acting intravenous anesthetic. A small electrical current is delivered through defibrillator pads placed on the chest to restore the normal rhythm of the heart.
The monitoring equipment allow continuous observation during the procedure.

Although generally safe, the procedure carries certain risks. These may include, but are not limited to:

- Skin burns at the pad sites
- Cardiac arrhythmias (usually transient, rarely severe)
- Cardiac arrest (very rare)
- Respiratory depression or arrest (rare)
- Allergic reactions to medications (rare)
- Transient low blood pressure

If the procedure is not performed, the arrhythmia may lead to impaired circulation, worsening symptoms, or the need for long-term medication therapy.
Alternative treatment options, including long-term medication therapy or surgical interventions, have been explained.

I understand the nature, purpose, and potential risks of electrical cardioversion. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I voluntarily consent to undergo **electrical cardioversion** and authorize the medical team to perform the procedure, including any necessary interventions related to potential complications.

Patient Name:	Physician Name:
_____	_____
Date: _____	Date: _____
Signature: _____	Signature: _____

Address: 1085 Budapest, Üllői street 26.
Postal address: 1085 Budapest, Üllői street 26.; 1428 Budapest, Pf. 2.
E-mail: titkarsag.pulm@semmelweis.hu
Tel.: (+36-1) 459-1500
semmelweis.hu