

Consent for Interventional Radiology Procedure

INTRODUCTION:

Your physician has requested that you undergo an interventional radiology procedure known as a _____

This procedure is being performed to further evaluate and/or treat your diagnosis of _____

We are asking you to read and sign this form so that we can be sure you understand the procedure and potential benefits, along with the associated potential risks, complications, alternatives, the likelihood of achieving the goals, and the recuperative process. Please ask questions about anything on this form that you do not understand.

PROCEDURE:

An interventional radiology procedure involves the placement of a fine needle through your skin and into a designated location. Some numbing medicine will be injected in the skin over the site that will be used before the needle is inserted. Intravenous medications may also be given to you to make you more comfortable and relaxed. This is known as moderate sedation.

Following insertion, the needle will be guided into position with a camera, using either x-rays (fluoroscopy or CT), sound waves (ultrasound) or magnetic signals (MRI). The position of the needle may be confirmed by the injection of x-ray contrast material (x-ray dye) and/or removal of fluid. If x-ray contrast material is injected into one of your veins or arteries, you may be asked to hold your breath for several seconds as some pictures are taken. During the injection of the x-ray contrast material, you may experience a warm feeling or a strange taste in your mouth. Both of these sensations are temporary and will go away soon. It may be necessary to make more than one pass of the needle to achieve the proper location. Depending on your condition, a drainage tube may be placed, a tissue sample taken or material injected through the needle.

PROCEDURE (cont'd):

The procedure planned for your condition is _____. At the completion of the procedure, the needle will be removed and pressure will be applied to the insertion site until the bleeding has stopped.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the needle insertion site, bleeding at the site, injury to a blood vessel, organ puncture, infection which may result in an infection of the blood stream, the development of a blood clot (embolization), and stroke. Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function. The medications used for the moderate sedation are associated with the risks of aspiration (inhaling food or liquid into your lungs) or respiratory depression. In addition to these potential risks associated with the procedure, the x-ray contrast material, and the moderate sedation medications, there may be other unpredictable risks including death.

(Complete this paragraph if applicable or document "NA")
Due to your additional medical history of _____,

added risks for you include but are not limited to:

_____.

ALTERNATIVES:

There may be other procedures that can be performed to further evaluate and/or treat your condition. If you are unsure about having an interventional radiology procedure performed, please discuss these other alternatives with your physician.

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AGREEMENT:

The information on this form was explained to me by _____. I understand the information and I have had the opportunity to ask any other questions I might have about the procedure, the reasons it is being performed, the associated risks, and the alternatives to the procedure. I agree to undergo the procedure to be performed by an authorized member of the Division of Vascular and Interventional Radiology and his/her associates, assistants, and appropriate hospital personnel, and accept the risks. I also agree that fellows, residents and surgical assistants may participate in significant tasks that are part of the procedure. In addition, I agree to have any other appropriate personnel present for the procedure.

I assign to the University of Pennsylvania Health System ("Health System") all rights to any tissues, organs, cells, body parts, and/or body fluids that may be removed during this procedure and I authorize the Health System to use or dispose of such specimens according to its standard practices.

The University of Pennsylvania Health System routinely suspends all resuscitative aspects of living wills and Do Not Attempt Resuscitation orders during the pre-procedure, procedural and post-procedural period, unless you specifically tell us otherwise. This applies to all invasive and operative procedures.

Signature: _____ Date: _____ Time _____
Patient

Signature: _____ Date: _____ Time _____
Authorized Healthcare Professional obtaining
and witnessing patient's signature

Signature: _____ Date: _____ Time _____
Attending physician (if applicable)

To be used if the patient is a minor, unconscious, or otherwise lacking decision making capacity.

I, _____, the _____
Relationship to patient
of _____ hereby give consent.

Signature: _____ Date: _____ Time _____
Legally Authorized Representative

Signature: _____ Date: _____ Time _____
Authorized Healthcare Professional obtaining
and witnessing representative's signature

Signature: _____ Date: _____ Time _____
Attending physician (if applicable)

Signature: _____ Date: _____ Time _____
Witness to telephone consent

