

# Consent for Diagnostic and/or Therapeutic Paracentesis

## INTRODUCTION:

Your physician has requested that you undergo a percutaneous drainage procedure to drain some or all of the fluid in your abdomen. This is known as paracentesis. 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:

A paracentesis involves the placement of a fine needle and/or thin tube through your skin and into the fluid. Some numbing medicine will be injected in the skin 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. The needle will be guided to the correct location by an ultrasound machine. Fluid will then be drained and may be sent for laboratory studies as appropriate. It may be necessary to make more than one pass of the needle in order to enter the collection.

## RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the needle insertion site, bleeding at the site, internal bleeding, injury to a blood vessel, organ puncture, and infection which may result in an infection of the blood stream. The development of any infection may result in the need for intravenous antibiotics. 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 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 alternatives to a paracentesis, including long-term catheter drainage and various types of shunts. If you are unsure about having a paracentesis, please discuss these possible alternatives with your physician.

## Consent for Diagnostic and/or Therapeutic Paracentesis

### 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

