

Consent for Port Removal

INTRODUCTION:

Your physician has requested that you undergo removal of a subcutaneous (under the skin) port. The reasons for removing the port may be that it is no longer needed, or it is infected and/or clotted. 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:

The removal of a port involves a small incision similar to the one made when inserting it. Some numbing medicine will be injected in the skin over the site. The port is dissected free and removed. The incision is closed with sutures after the port is removed. If the port is infected, and there is pus in the pocket, the incision will be left open to allow the wound to heal from the inside out. Gauze material known as packing will be inserted and you will be asked to return at regular intervals to repack the wound and assess healing. Very rarely, additional measures such as plastic surgery could be needed.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the removal site, bleeding at the site, injury to a blood vessel, entrance of air into the vein (air embolus), and infection which may result in an infection of the blood stream.

(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:

The alternative to removing the device is to leave it in place. If it infected, this is not a viable alternative. If you are unsure about having your port removed, 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

