Consent for Percutaneous Fluid Collection/Abscess Drainage

INTRODUCTION:

Your physician has requested that you undergo a percutaneous drainage procedure to treat the fluid collection/abscess in your ________________________________. 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 percutaneous drainage procedure involves the placement of a fine needle through your skin and into the fluid collection/abscess. 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 x-ray camera, CT scanner, MRI or ultrasound machine. The position of the needle will then be confirmed by the injection of x-ray contrast material (x-ray dye) and/or removal of fluid. Fluid will be sent for laboratory studies as appropriate. X-ray pictures will be taken. It may be necessary to make more than one pass of the needle in order to enter the collection. Depending on the nature of the fluid, a drainage tube may or may not be placed. If a drainage tube is placed it will be inserted through the skin and secured in place. It may need to stay in place for a variable amount of time to allow the collection to drain. Drainage tubes often become plugged after time, which may result in the need to replace the tube at a future date. If not replaced, a plugged tube may result in a serious infection. After some time, usually when the fluid drainage has decreased and your condition has improved, you will return for evaluation of the tube for possible removal.

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. Risks associated with the x-ray contrast material include an allergic reaction. 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 or manage your fluid collection. If you are unsure about having a percutaneous drainage procedure, 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

1/02, 4/05, 8/06, 10/07, 11/09