Consent for Feeding Tube Check and/or Change

INTRODUCTION:

Your physician has requested that you undergo a feeding tube check and/or change to manage your feeding tube. We are asking you to read and sign this form so that we can be sure you understand the risks and complications potentially associated with this procedure. Please ask questions about anything on this form that you do not understand.

PROCEDURE:

A feeding tube check involves injecting x-ray contrast material (x-ray dye) through the tube and taking x-ray pictures. A feeding tube change involves passing a wire through the tube in your stomach or small intestine, removing the tube over the wire and then replacing it with another tube. After the new tube is inserted, the wire is removed. Some numbing medicine will be injected in the skin before the wire is inserted and the tube changed. Intravenous medications may also be given to you to make you more comfortable and relaxed. This is known as moderate sedation. The procedure will be guided by an x-ray camera. The position of the tube will then be confirmed by the injection of x-ray contrast material (x-ray dye) and/or removal of fluid. X-ray pictures of the area will then be taken. Depending on your condition, a new feeding tube may be placed. If a new feeding 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. Feeding tubes often become plugged after time, which may result in the need to replace the tube at a future date.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the tube 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 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 or manage your feeding tube. If you are unsure about having a feeding tube check/change procedure, please discuss these other alternatives with your physician.
Consent for Percutaneous Feeding Tube Check and/or Change

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