INTRODUCTION:

Your physician has requested that you undergo an interventional radiology procedure known as a transjugular liver biopsy. This procedure is being performed to further evaluate your diagnosis of liver disease. 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 transjugular liver biopsy involves the placement of a plastic tube (catheter) into a vein in your neck. Some numbing medicine will be injected in the skin over the vein that will be used before the catheter is inserted. Intravenous medications may also be given to you to make you more comfortable and relaxed. This is known as moderate sedation. Once the catheter has been placed into the vein, it will be advanced through the blood vessels and into the hepatic vein (a liver vein). During this time, x-ray contrast material (x-ray dye) may be injected through the catheter and x-ray pictures taken. You may be asked to hold your breath for several seconds as these pictures are taken. During the injection of 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. Once the catheter is placed into the hepatic vein, a long needle will be passed through the tube and used to obtain liver tissue (biopsy) which will be sent to Pathology for further study. During the needle passage, you may experience brief discomfort. 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. To help prevent bleeding, it will be very important for you to lie in bed for up to four hours.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the catheter insertion site, bleeding at the site or into the abdomen, injury to a blood vessel or the liver, infection which may result in an infection of the blood stream, disturbances in heart rhythm (arrhythmia), and shock. 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 your condition, including percutaneous (through the abdominal wall) liver biopsy. If you are unsure about having a transjugular liver biopsy performed, please discuss these other alternatives with your physician.
Consent for Transjugular Liver Biopsy

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