CONSENT FOR
CENTRAL VENOUS CATHETER PLACEMENT

INTRODUCTION: Your physician has requested that you have a central venous catheter inserted. This catheter will allow your condition to be more closely monitored and can be used for the administration of intravenous fluids, medications and nutrition. 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 central venous catheter is a thin, sterile plastic intravascular tube that is inserted into a large blood vessel (central vein) in your neck, upper chest or groin. Before the catheter is inserted, numbing medicine will be injected in the skin over the blood vessel that will be used. A needle will guide the entry of the catheter through the skin, a small incision will be made and catheter will be entered into the appropriate vessel. Once the catheter is correctly positioned, the outside end of it will be sutured to your skin and then covered with a bandage. If the catheter is inserted into a vessel in either your neck or upper chest, a chest x-ray will be taken to make sure that it is in the correct location once the insertion procedure is finished. An x-ray is not needed if the catheter is inserted into a vessel in your groin.

RISKS: Risks associated with the insertion of a central venous catheter include but are not limited to damage to the local vein or artery; bleeding; localized pain; infection at the insertion site or a blood stream infection; blockage of the blood vessel; and injury to the chest or lungs including bleeding (hemothorax) or a collapsed lung (pneumothorax). The development of an infection may result in the need for antibiotics. In addition to these potential risks associated with a central venous catheter insertion, there may be other unexpected risks or complications, 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 ways to monitor your condition and collect the information that is obtained by a central venous catheter, along with other ways to administer intravenous fluids, medications and nutrition. These include administering fluid, medication and nutrition through a peripheral intravenous catheter. A peripheral intravenous catheter will need to be removed and replaced on a regular basis. If you are unsure about undergoing insertion of a central venous catheter, please discuss these possible alternatives with your physician including the relevant risks, benefits and side effects related to the alternatives and the possible result of not receiving care, treatment and services.
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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 questions that I might have regarding the insertion of a central venous catheter, the reasons it is being performed, the associated potential risks and complications, and the possible alternative forms of treatment. I agree to undergo the procedure to be performed by ___________________________ 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 the 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 of Authorized Healthcare Professional obtaining & witnessing patient’s signature / ____________________________ Date: ________ Time: ________

Print Name

Signature of Attending Physician (if applicable) / ____________________________ Date: ________ Time: ________

Print Name

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To be used if the patient is a minor, unconscious or otherwise lacking decision making capacity.

I, ____________________________, the ____________________________ of ____________________________

Name Relationship to patient Patient’s name hereby give consent on his/her behalf.

Signature: ____________________________ Date: ________ Time: ________

Legally Authorized Representative

Signature of Authorized Healthcare Professional obtaining & witnessing representative’s signature / ____________________________ Date: ________ Time: ________

Print Name

Signature of Attending Physician (if applicable) / ____________________________ Date: ________ Time: ________

Print Name

Signature: ____________________________ Date: ________ Time: ________

Witness to telephone consent

DO NOT USE UNAPPROVED ABBREVIATIONS