First Hill
SURGERY CENTER

Port – Indwelling Vascular Access Device Removal Consent Form

Patient Name: _____ Date of Birth: _____

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended

1 MY PROCEDURE

I hereby give my consent for Dr. _____ to perform a minor surgical procedure for REMOVAL of an **Indwelling Port, which is a Vascular Access Device**. The procedure is performed at First Hill Surgery Center by a Vascular Surgeon. This has been recommended to me by my primary or consulting physician

I understand that the procedure generally entails the following:

That I might have an IV peripheral inserted in my arm. For my comfort, a local skin anesthesia with Lidocaine, will be injected into the skin surrounding the access device. Also, conscious sedation agents, which have amnesic properties, may be administered to make me feel sleepy. My chest and neck area will be cleansed first with antibacterial solution then I shall be covered by a sterile drape. A small surgical incision will be made in my chest and the small access device (port) and the catheter line threaded under my skin will be removed. If the catheter line is adhered to my vessel, the physician might loosen it by a balloon angioplasty technique involving a small, temporary catheter threaded inside my catheter, the attached balloon is inflated (angioplasty) releasing my catheter from adhered tissue. This step, if necessary, lasts only a few seconds and typically does not injure my vein. The small incision will be closed with internal sutures and then glue/steri-strips placed on the surface of the skin. I should keep the area clean and dry until the skin fully heals.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Removal of device that may be physically unappealing or no longer functional
- Removal of the device may prevent the vein the catheter is threaded into from becoming stenotic (stiffen).

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure. **These could include but may not be limited to the following:**

- ❑ infection or bleeding
- ❑ retention of catheter parts requiring additional procedures to complete the removal
- ❑ clots in the veins (could cause neck/arm swelling and require blood thinner)

- ❑ reaction to the medications including over-sedation, where my breathing effort diminishes and I might require ventilation support
- ❑ other rare complications are also possible

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

I understand these special risks of this procedure and that these can be affected by obesity, diabetes, smoking, and other factors.

4 **MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to observation only. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Port Removal** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ **Date:** _____ **Time:** _____

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ **Date:** _____ **Time:** _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME