First Hill
SURGERY CENTER

Port-a-cath Insertion 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 by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr._____to perform a **Port-a-cath Insertion** upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to treat a disease**.**

I understand that the procedure or treatment can be described as follows:
An incision will be made in your chest and a "port" or small disc will be inserted under the skin with a soft thin tube called a catheter connecting the port to a large vein.

This procedure may require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Treatment of breast cancer via chemotherapy
- Access for blood draws

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
- ❑ bleeding
- ❑ pneumothorax (collapse of the lung, possibly requiring placement of a tube in the chest)
- ❑ clots in the veins (could cause neck/arm swelling and require blood thinner)
- ❑ malfunction of the catheter, requiring revision
- ❑ 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 **Portacath Insertion** 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

Physician Signature:_____ **Date:**_____ **Time:** _____