Affix Patient Label

Patient Name: Date of Birth:

Informed Consent: Chest Port Removal

This information is given to you so that you can make an informed decision about having a **chest port removed.**

Reason and Purpose of this Procedure:

To remove the chest port and its catheter:

____

____

The physician will open the incision in your chest wall above your port pocket. The port will then be freed up from the scar tissue that has formed around it. The port and the catheter will be removed. The port pocket will be sutured closed and a dressing applied. Sometimes it is necessary to make an incision at the base of the neck to remove the catheter.

Local anesthetic will be injected at the vein puncture site, around the pocket, and in between those locations. You will be given some intravenous medication to relax you and for pain during the procedure. For most patients, the procedure is well tolerated.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Remove the no longer needed or malfunctioning or infected port and catheter.
- Help clear any infection involving the port or catheter.
- Help your body dissolve any blood clots that have formed around the catheter.
- ____

Risks of this Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- **Bleeding.** If excessive you may need a blood transfusion. This is rare.
- **Infection.** Can occur in the port pocket. You may need antibiotics. It is important you follow instructions about caring for your dressing.
- **Inability to remove the entire catheter.** This is rare but may require additional procedures.
- **Injury to adjacent organs or body structures.**
- **Complications from sedation medicine.** You may have low blood pressure. You may have breathing problems including slow breathing and choking on vomit (aspiration). If you are sedated you will be monitored by a nurse and given oxygen to breath.

Potential Radiation Risks:

- **Any exposure to radiation may cause a slightly higher risk for cancer later in life.** This risk is low.
- **Skin rashes.** Skin rashes may lead to breakdown of skin and possibly severe sores. This is rare.
- **Hair loss.** This does not happen to everyone. This can be temporary or permanent.
- **It is possible we may have to use higher doses of radiation.** If we do, we will tell you.
- **If you see changes with your skin, you should report them to your doctor.**

Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Risks Specific to You:

____

____

____

____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure.
- ____________________

If you Choose not to have this Treatment:

- Your doctor may find it more difficult or not possible to treat your problem.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure, the doctor may need to do more tests or treatment.

Students, technical salespeople, and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be taken during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Affix Patient Label

Patient Name: Date of Birth:

By signing this form, I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: ☐ **Left** ☐ **Right** ☐ **Bilateral | Chest Port Removal** ________________________________

  ____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature: ____ Date: __________ Time: __________

Relationship: ☐ **Patient** ☐ **Closest relative (relationship)** ________________ ☐ **Guardian/POA Healthcare**

Reason patient is unable to sign: ____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: ______________________________ ID #: __________ Date: __________ Time: __________

Telephone Consent ONLY: *(One witness signature MUST be from a registered nurse (RN) or provider)*

1st Witness Signature: ____________ 2nd Witness Signature: ____________ Date: ___________ Time: ___________

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: ____ Date: ___________ Time: __________

Teach Back:

Patient shows understanding by stating in his or her own words:

_______ Reason(s) for the treatment/procedure: ____

_______ Area(s) of the body that will be affected: ____

_______ Benefit(s) of the procedure: ____

_______ Risk(s) of the procedure: ____

_______ Alternative(s) to the procedure: ____

OR

_______ Patient elects not to proceed: ______________________________ Date: ___________ Time: ___________
(Patient signature)

Validated/Witness: ____ Date: ___________ Time: ___________