BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Radiology Guided Tube Check with Possible Change or Removal

This information is given to you so that you can make an informed decision about having a **radiology guided tube check with possible change or removal.** This procedure is most often done with moderate sedation or anesthesia.

Reason and Purpose of this Procedure:

A **tube check** with possible change or removal is to treat fluid collection or abscess. A tube check is done by injecting x-ray dye into the tube. Then an x-ray is taken. This allows the radiologist to see the placement and function of your drain.

A **tube change** is done by passing a wire through the tube. The tube is taken out over the wire and replaced with another tube. The procedure is guided by x-ray. After the new tube is put in place, the wire is removed. The position of the tube is checked by the injection of x-ray dye and/or removal of fluid. After placement, the drainage tube is attached to a suction bulb or other device.

Local anesthetic may be injected at the drainage site and you may be given some intravenous relaxing medication and pain medicine during the procedure. For most patients, the procedure is well tolerated. Some patients will have moderate discomfort. This is usually well controlled with the intravenous relaxing and pain medication. If general anesthesia or stronger sedation is needed, your doctor will discuss that with you.

A **tube removal** involves pulling the tube out. A dressing is placed at the site.

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.

- More drainage of fluid.
- Less leaking at the insertion site.
- Removal of drain.

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.

- **Pain or discomfort at the tube insertion site.** Numbing medicine and/or sedation medicines can help this.
- **Bleeding at the site.** This typically stops with time and a site dressing.
- **Internal bleeding or injury to a blood vessel.** You may need surgery or blood transfusion. This is rare.
- **Unintended organ puncture.** This may require more treatment. Including an embolization to stop bleeding.
- **Infection.** Either at the site or in the blood stream. You may need intravenous antibiotics.
- **Allergic reaction from the x-ray contrast material.** Reactions are typically mild. More medicines may be given to reduce symptoms.
- **Reaction to the sedation medications.** The most common reactions are nausea and vomiting. In rare cases, death may occur. You will be continually monitored with lifesaving equipment.

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.

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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.

Risks Specific to You:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Surgery may be an option.
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- The fluid collection or abscess may not go away.
- Site may become infected.
- Tube may no longer work properly.

Information on Moderate Sedation:

You will be given medicine in an IV to relax you. This medicine will also make you more comfortable. This is called "moderate sedation". You will feel sleepy. You may even sleep through parts of your procedure. We will monitor your heart rate and your blood pressure. We will also monitor your oxygen level.

If your heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may be unable to reverse the sedation. We may need to support your breathing.

Even if you have a NO CODE status:

- You may need intubation to support your breathing.
- You may need medications to support your blood pressure.

We will re-evaluate your medical treatment plan and your NO CODE status when sedation has cleared your body.

Benefits of Moderate Sedation:

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.

- Less pain during the procedure.
- Less anxiety or worry.
- Decreasing your memory of the procedure.

Risks of Moderate Sedation:

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. The list includes:

- Decreased breathing during the procedure and dropping oxygen levels. To help you breathe, a tube may be placed into the mouth or nose and into the trachea to help you breathe.
- Allergic reactions: nausea & vomiting, swelling, rash.

- Vomit material getting into the lungs.
- A drop in blood pressure. This needs fluids or medicine to increase blood pressure.
- Heart rhythm changes that may require medicines to treat.
- Not enough sedation or analgesia resulting in pain or discomfort.

Your physical and mental ability may not be back to normal right away. You should not drive or make important decisions for at least 24 hours after the procedure.

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.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

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.

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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**

  Radiology Guided Tube Check with Possible Change or Removal_____

  Tube Location: _____
- 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: _____