30737
CH-3494 (JAN 12)
Effective 2012

Indiana University Health

CONSENT FOR BEDSIDE PROCEDURE (Page 1 of 1)

By signing this form, I agree to the procedure(s) listed here:

- ☐ Arthrocentesis
- ☐ Aspiration _____
- ☐ Biopsy _____
- ☐ External Ventricular Drain
- ☐ Incision & Drainage
- ☐ Insertion of Arterial Line
- ☐ Insertion of Central Lines Including PICC
- ☐ Insertion of Chest Tube
- ☐ Insertion of Pulmonary Artery Catheter
- ☐ Intra Cranial Pressure Monitoring
- ☐ Paracentesis
- ☐ Percutaneous Endoscopic Gastrostomy Tube
- ☐ Percutaneous Needle Aspiration
- ☐ Thoracentesis
- ☐ Other: _____

to be done by _____, members of Indiana University Health Medical Staff or other appropriate licensed personnel.

From this point on:

- all procedures will be called the "Procedure".
- the people performing the Procedure will be called "Treating Practitioner".

The exceptions to my consent are:

_____

_____

I understand and agree that:

- Residents and students may help with my care.
- Medical staff other than the Treating Practitioner may do part of my Procedure.
- Industry representatives may be in the room to consult during my Procedure.
- The Treating Practitioner may do other procedures not listed here if they are needed.
- A bad outcome may occur. A bad outcome does not mean care was not appropriate.
- The Anesthesiologist or Treating Practitioner may give me an anesthetic. I have been told about the risks of anesthesia. These include death, injury to my teeth, throat and mouth, other injury and damage to my dentures.
- Parts of my body taken out during the procedure can be thrown away or used for research as long as my name is not used.
- Pictures may be taken and used for teaching as long as my name is not used.
- I have talked with the Treating Practitioner about:
  - ○ The Procedure
  - ○ Why I need it
  - ○ The expected outcome
  - ○ The risks
  - ○ The chances of success
  - ○ Risks, benefits and results of other treatments
  - ○ What could happen if I do not have the Procedure
- I have been told about other choices, including:
  - ○ Not having the Procedure
  - ○ Other procedures
  - ○ Medicine
  - ○ Therapy
  - ○ Other choices: _____
- I have been told about risks of the Procedure, which include:
  - ○ Bleeding
  - ○ Infection
  - ○ Injury
  - ○ Damage to parts of my body
  - ○ Scarring
  - ○ Death
  - ○ Other risks: _____

_____
Signature of Patient/Surrogate

_____
Time Signed Date Signed

_____
If Signed by Surrogate, Relationship to Patient

OPTIONAL

_____
Additional Adult Witness Signature

_____
Time Signed Date Signed

TREATING PRACTITIONER USE ONLY

I have discussed with the patient the nature of the proposed care, treatment, services, medications, interventions or procedures; the potential benefits, risks or side effects, including potential problems related to recuperation; the likelihood of achieving care, treatment and service goals; the reasonable alternatives to the proposed care, treatment and service; the relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations on the confidentiality of information learned from or about the patient.

Signed: _____ **Date:** _____ **Time:** _____

DOCUMENTATION OF EMERGENT/URGENT PROCEDURE

This procedure was performed emergently.

Signed: _____ **Date:** _____ **Time:** _____

Indiana University Health

UNIVERSAL PROTOCOL CHECKLIST

To be completed by Licensed Professional

Patient Sticker

Procedure(s): _____

Date of Procedure: _____

PRE-PROCEDURE ITEMS ADDRESSED AND MATCHED TO PATIENT

	INITIAL BOX YES	INITIAL BOX N/A
Correct patient verified using 2 patient identifiers		
The proceduralist available		
History and Physical or Current Clinical Note for bedside procedures		
Consent form(s) accurate, completed and signed		
Pre-Sedation/Pre-Anesthesia Assessment		
Diagnostic, radiology, pathology or biopsy results available		
Implants/Devices or special equipment available		
Any required blood products available		
Site marked with ***"YES"*** by proceduralist(s) or qualified designee		
Alternative to site marking		

Time Completed: _____

FIRST TIME-OUT: COMPLETED ON PATIENT ENTRY TO PROCEDURE AREA/PRIOR TO BEDSIDE PROCEDURE

	INITIAL BOX YES	INITIAL BOX N/A
Allergies Verified		
Procedures match consent		
Verbal acknowledgement from all members of the Procedure team who are present		

Time Completed: _____

SECOND TIME-OUT: REQUIRES ACTIVE COMMUNICATION AMONG ALL MEMBERS OF THE PROCEDURE TEAM INCLUDING THE PHYSICIAN/PROCEDURALIST

	INITIAL BOX YES	INITIAL BOX N/A
Correct patient verified using 2 patient identifiers		
Correct site confirmed and marked		
Verbal agreement procedure(s) match consent		
Relevant images displayed and labeled with correct patient identifiers		
Antibiotic administered		
Fluids available for irrigation or flushes		
DVT/VTE prophylaxis		
Safety Precautions based on patient history or medication use		
Correct patient position		
Verbal acknowledgement from all members of the procedure team		

Time Completed: _____

CLOSING TIME-OUT/UPON COMPLETION OF PROCEDURE

	INITIAL BOX YES	INITIAL BOX N/A
Consents reviewed – all procedures have been completed		
Specimens addressed, labeled and identified		
All foreign bodies not intended for implantation have been removed		
Counts addressed *(for OR and other invasive procedural areas)*		
Verbal acknowledgement from all members of the procedure team		

Time Completed: _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____

Indiana University Health

CENTRAL LINE INSERTION CHECKLIST

Patient Unit Location: _____

Date: _____ Time: _____

LINE INDICATION (Mark all that apply)

☐ Bedside Procedure Consent Obtained
If NOT obtained, reason: _____
☐ Universal Protocol Checklist Completed

☐ New Line Placement ☐ Changed Over a Wire ☐ Emergent Placement

Reason/ Indication for Change: _____

INSERTION SITE:	☐ Right ☐ Left	☐ EJ	☐ IJ	☐ SC	☐ Long Arm	☐ Femoral
PREP:	☐ Chloraprep	☐ Betadine	☐ Alcohol		☐ Duraprep	☐ Prevail
Sterile Protocol:	☐ Hat, Mask, Sterile Gown, Sterile Gloves, Large Sterile Sheet, and Hand Hygiene (MANDATORY)					

Site Prep Guidelines:
- Chloroprep scrub (more than 2 mos) 30 seconds
- Betadine for less than 2 mos

TYPE:	☐ Single	☐ Double Lumen	☐ Triple Lumen	☐ Quad Lumen	☐ Sheath	☐ Long Arm ☐ Other:
SIZE:	☐ 6	☐ 7	☐ 8.5	☐ 9	☐ 12	

TECHNIQUE:	☐ Seldinger	☐ OTHER: _____	**GRADE:**	☐ Simple	☐ Multiple Attempts	More than 1 Site Attempted: ☐ Yes ☐ No
POSITION:	☐ SVC/ RA ☐ X-Ray Confirm	☐ Ultrasound Guidance	☐ Blood Return ☐ All Ports	Flush: ☐ Saline ☐ Heparin	Kits Opened/ Used: Number of kits opened: _____ Number of Wires Removed: ____	☐ All wires accounted for: ☐ Yes ☐ No ☐ Other _____

Justification if Femoral Line ***(adult only):*** _____

Justification if Femoral Line ***(adult only):*** _____

Line Placement Performed By: _____ Assistant: _____

Personnel at Bedside	**Yes**	**Needed Reminder**	**No**
Hand Hygiene	☐	☐	☐
Sterile Attire	☐	☐	☐
Full Drape (*100% of bed*)	☐	☐	☐
Sterile Field Maintained	☐	☐	☐
RN/Others in room			
Hand Hygiene	☐	☐	☐
Proper Attire	☐	☐	☐

Minimum proper in-room attire for other in room:
Mask and Cap

Please provide details for any "NO**" response: _____

Complications: _____

☐ **Guidewire Removed (N/A in NICU)** ☐ Stiffener/ Obturator Removed (N/A in NICU)
☐ Sterile Dressing Applied
Dressing with BioPatch: ☐ Yes ☐ No Reason if "**NO**": _____ ***(pediatric only)***

Form Completed By: _____

RETURN FORM ACCORDING TO UNIT/DEPARTMENT PROCESS
Not a Part of the Permanent Medical Record