



R M 2 C 5 2 2



Stony Brook
Medicine

Stony Brook, NY 11794

Central Venous Line Insertion Procedure Note

Patient Allergy _____

Pre Procedure Time-Out:

Procedure to be performed: _____ (initials)

- The patient was correctly identified by name and date of birth (____) (____)
- The correct procedure is planned (____) (____)
- The consent form is complete and accurate; or emergent consent is documented (____) (____)

Provider Signature: _____ ID# _____ Date _____ Time _____ Initials _____

Verifier Signature: _____ ID# _____ Date _____ Time _____ Initials _____

Procedure note:

- Operator: _____
- Supervisor: _____
- Other participants: _____
- Procedure (circle one): (Double Lumen/ Triple Lumen/ Introducer cordis/ Dialysis catheter) positioned at the (L/R) (Internal Jugular/ Subclavian/ Femoral) vein site
- Ultrasound guidance used: Y N
If Yes, Sterile Sheath used for transducer probe Y N, Explain _____
- Consent: Obtained and on chart;
 Not Obtained, Emergent condition; Not Obtained, other, explain _____
- Standard sterile technique used: Y N, Explain _____
- Local Anesthesia used: Y N
If yes, state name and amount of anesthetic _____
- Complications: _____
- Estimated Blood Loss: _____
- Comments: _____

Provider Signature: _____ ID# _____ Date _____ Time _____

Post Procedure checks:

- Guidewire removed and visualized at end of procedure: (two initials) (____) (____)
Kits opened _____
guidewires verified _____

All sharps and equipment accounted for and appropriately discarded

X-ray ordered Imaging not immediately indicated

Comments: _____

Provider Signature: _____ ID# _____ Date _____ Time _____ Initials _____

Verifier Signature: _____ ID# _____ Date _____ Time _____ Initials _____



CENTRAL LINE CONSENT / INSERTION FORM

I request and consent to a central line insertion procedure. This procedure will be performed by _____
_____ and/or his associate (s) and any assistants he/she designates.

I understand that the purpose of this procedure is _____
_____ (Practitioner must describe procedure in non-medical

terms) I have been advised that this procedure may have risks, complications or adverse consequences associated with it including but not limited to: **Bleeding, infection, thrombosis (blood clot), phlebitis (blood vessel irritation), malposition, arrhythmia, decreased perfusion to extremity, arterial injury, pneumothorax (air leak around the lung)**

I have been advised of the alternatives, the risks, benefits and side effects related to the alternatives.
I consent to the administration of sedation as deemed necessary.
I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.
I also understand that portions of the procedure may be photographed or videotaped and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for teaching. I also understand that students/trainees may be present during this procedure and they may observe or assist in my care, under the direction of my physician and other hospital staff members.
I understand that in the event one or more of my healthcare providers sustains a needlestick/sharp injury or exposure to my blood/bodily fluids that blood may be drawn and may be tested for hepatitis and the result of that hepatitis testing disclosed to the health care providers who sustained the exposure.

I impose no specific limitations or restrictions on my treatment other than _____
_____ (Patient must complete or write "none").

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. All blank spaces have been either completed or lined out prior to my signing this document.

Signature of Patient, Parent, Guardian, Health Care Agent or other representative of patient	Relationship (if other than patient)	Date
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Signature/ID# of Practitioner	Date	Time
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Signature of Witness (Age 18 or older, other than practitioner performing procedure)	Title or Relationship to patient	Date
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I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services.

Signature/ID# of Practitioner	Date	Time
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An interpreter or special assistance was used to obtain consent from this patient _____
(Name of Interpreter)

