

**Peripherally Inserted Central  
Catheter (PICC) Consent**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

I understand that the Peripherally Inserted Central Catheter (PICC) is a thin, flexible tube inserted in a vein near the bend of the elbow. The catheter will be placed to prevent frequent needle sticks, for giving medications, fluids, nutrients and/or getting blood samples. The PICC catheter may be placed in either arm and is advanced into the vein above the heart. Occasionally, children may require placement of the catheter in a vein in the leg (saphenous vein) or the scalp (temporal vein).

I further understand that the PICC catheter will be inserted by a registered nurse or a physician specially trained in this procedure. The procedure will take approximately one hour and I may experience slight discomfort. Following careful cleansing of the skin, the catheter will be threaded through an insertion needle to a pre-determined location. The catheter will be taped in place and a sterile dressing will be applied at the entry site. An x-ray will be done to confirm placement of the catheter.

I have been informed that registered nurses will care for the catheter and the dressing will be changed at least once a week. If the dressing becomes soiled, loosened or the site becomes reddened or painful, I will notify my nurse. The catheter will be flushed routinely to maintain an open line.

I have been advised of the risks of this procedure which include but are not limited to infection; malposition of the catheter, formation of blood clots, thrombosis, embolism, tendon or nerve damage and irregular heart beat.

I, \_\_\_\_\_, hereby consent to the placement of a PICC Catheter.

WITNESS:	PATIENT SIGNATURE:
REASON PATIENT UNABLE TO SIGN:	PERSON AUTHORIZED TO SIGN FOR PATIENT-SIGNATURE:
	RELATIONSHIP TO PATIENT:

Time out completed to verify correct patient identity, correct procedure and correct site

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

I have explained risks and benefits and alternatives to this patient and/or representative.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**TRANSLATION:**

This is to certify that the above Consent has been read to the patient (or representative in his/her native language; all representations which appear in the Consent were understood and authorized by the patient (or representative).

Interpreter's printed name: \_\_\_\_\_

Interpreter's signature: \_\_\_\_\_

