Penn Medicine
Chester County Hospital

□ HUP □ CCH □ CPUP □ Radnor

□ PAH □ PPMC □ Other ___________

PENN Wound Care Center
Consent for Wound Care

INTRODUCTION: Due to your diagnosis of ______________________, your physician has ordered that you receive wound care. Wound care treatment may include physical examinations; debridements; dressing changes; compression therapy; skin substitutes; the use of off-loading devices to relieve pressure on the wound; diagnostic procedures; lab tests; and x-rays or other imaging studies. Wound care treatment is being performed to improve healing of your wound and reduce the risks of infection, along with the possible need for skin grafting or an amputation. We are asking you to read and sign this form so that we can be sure you understand your wound care treatment plan and its potential benefits, along with the associated potential risks, complications, alternatives, likelihood of achieving the goals, the prognosis, and the recuperative process. Please ask questions about anything on this form that you do not understand.

PROCEDURES:

Wound Debridement: Wound Debridement involves the removal of unhealthy or necrotic (dead) tissue from the wound to promote healing. Removing unhealthy or necrotic tissues from a wound helps to keep it clean and heal faster. Prior to performing a debridement, the wound will be cleansed with a prep solution and, if needed, topical or locally injected anesthetic medication will be given. A sharp instrument will then be used to remove the unhealthy or necrotic tissue. This type of debridement is called sharp debridement. Following debridement, the wound will be covered with a dressing. Sometimes a medication is applied to the wound that will assist in the breakdown of unhealthy or necrotic tissue. This is called chemical debridement. Multiple debridement procedures may be needed to treat your wound. The removal of unhealthy or necrotic tissues from around the edges of around may result in the wound becoming larger.

Compression Therapy: Compression therapy is a continuous external pressure for the management of venous leg ulcers and lymphedema-related leg ulcers. This therapy provides sustained graduated compression with the use of multi-layer compression bandaging that will be wrapped from your toes/foot to just below your knee. By countering the effects of venous pressure, compression therapy reduces swelling and promotes venous and lymphatic return.

Skin Substitutes: Skin substitutes, also referred to as artificial skin, are biosynthetic materials that are used for treatment of acute and chronic non-healing wounds and soft tissue grafting. Skin substitutes are used to provide temporary wound coverage; provide complete wound closure; reduce healing time; lessen pain; minimize postoperative contracture; and improve appearance and function. The skin substitute material is applied to the wound and acts as a cover, providing a moist environment that promotes your own cells to heal the wound. Once the material is in place, a protective dressing will be applied.

RISKS: The specific risks associated with wound care include but are not limited to bleeding; pain; infection; scarring; prolonged healing; failure to heal; and the need for an amputation. If you are undergoing wound debridement additional risks include but are not limited to: damage to nearby blood vessels, tissue, or organs; an allergic reaction to the topical or injected anesthetic medication; an allergic reaction to the skin prep solution; and removal of healthy tissue.

(Complete this paragraph is applicable or document "NA".) Due to your additional medical history of _________________________________, added risks for you include but are limited to:___________________________
____
____.

ALTERNATIVES: There may be other ways to treat your wound, such as with dressing changes only, that do not involve a debridement; hyperbaric oxygen treatment; or surgery to cover the wound with a skin graft. If you are unsure about undergoing wound care with either debridement, compression therapy, or skin substitutes, please discuss these possible alternatives with your physician. If you do not undergo either wound debridement, compression therapy, skin substitutes, or any other type of treatment of your wound, you are at risk for worsening of the wound which may result in infection and the need for an amputation.

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AGREEMENT: The information on this form was explained to me by _____________________________________. I understand the information and I have had the opportunity to ask any questions that I might have regarding wound care; the reasons the procedure is being performed; the potential benefits; the associated potential risks and complications; and the possible alternative forms of treatment. I agree to undergo the procedure, to be performed by __________________________________ and his/her associates, assistants, and appropriate hospital personnel, and accept the risks. I agree that fellows, residents and medical assistants may participate in the procedure. I also agree to have any other appropriate personnel present for the procedure.

I understand that during my wound care, photographs of my wound and the surrounding area may be taken. These photographs will be used for treatment purposes including the assessment and evaluation of my wound.

I understand that during this procedure, certain of my tissue(s), bodily substances and/or fluids may be removed and used, disposed of, or transferred by Penn Medicine for educational and research purposes not specifically related to my treatment.

Patient Signature:_____________________________ Print Name:______________________ Date: ______ Time: _____

Authorized Health Care Professional obtaining and witnessing patient signature

Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____

Attending Physician (if applicable):
Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____

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To be used if the patient is a minor, unconscious or otherwise lacking decision making capacity.

I, ____, the ____________________________________
Name Relationship to Patient

of ____, hereby give consent on his/her behalf.
Patient's name

Legal Authorized Representative
Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____

Authorized Health Care Professional obtaining and witnessing patient signature
Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____

Attending Physician (if applicable):
Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____

Witness to telephone consent:

Signature:___________________________________ Print Name:______________________ Date: ______ Time: _____