Hartford Hospital
A Hartford HealthCare Partner

6816

CONSENT FOR PERITONEAL DIALYSIS

I, _____ have been informed that my kidneys are not functioning and that I
name of patient
need dialysis to sustain my life. I understand that while dialysis is a life-sustaining procedure, it is not

a cure for kidney failure.

The procedure necessary to treat my condition has been explained to me by my physician, and I understand the nature of the procedure to be as follows:

Peritoneal dialysis involves the introduction of a special fluid into my peritoneal cavity (abdomen) at a frequency prescribed by my doctor, seven (7) days per week. The fluid is left in my abdomen for a set period of time to absorb certain impurities and other chemicals from my blood. Once the impurities are absorbed, the fluid is drained out of my abdomen. I also understand that, along with the peritoneal treatment, I may need laboratory tests, radiology and surgical procedures to assure adequate function of the equipment and effectiveness of the treatment.

I have been informed that the following risks are associated with peritoneal dialysis and that while such risks are not common, one or more can occur, and be potentially life threatening:

- Bacterial, fungal, mycobacterium or viral contamination of my abdominal cavity, which can result in an infection known as peritonitis. Although usually treatable, peritonitis is potentially a serious condition that can lead to abdominal abscesses, and even death.
- Irregular heartbeats, headaches, decrease in blood pressure and mild confusion may result from certain chemical shifts and imbalances occurring within my system.
- Internal hernias, fluid accumulation in the chest (heart and lungs), obesity, rectal pain, and high blood fat levels and pancreatitis.
- Malnutrition, including protein loss, which may require certain dietary changes on my part.
- Allergic and toxic reactions to drugs, solutions, artificial kidneys or other equipment used during the hemodialysis treatment;
- Treatment failure with peritoneal dialysis, which may result in the recommendation that I receive hemodialysis treatment.

I understand that it is necessary for me to follow certain dietary restrictions regarding my dietary intake. It is my responsibility to follow the restrictions in order to avoid various complications resulting from my failure to adhere to the prescribed diet. In addition, I understand the importance of adhering to the medication regimen as prescribed by my physicians and I will follow it exactly. Failure to take my medication can result in bone disease, skin ulcers, anemia, heart failure and calcification of my heart and blood vessels. Overall, I understand that my well-being depends on my willingness to comply with the entire treatment regimen, not just the peritoneal dialysis treatment. I also agree to undergo my dialysis as prescribed by my physician since failure to do so may result in serious complications, including death.

Hartford Hospital
A Hartford HealthCare Partner

CONSENT FOR PERITONEAL DIALYSIS

I am aware that long-term peritoneal dialysis will not cure my kidney disease. It is offered as a substitute to carry out some of the functions that my kidneys are no longer able to perform. I am aware that there may be alternatives to peritoneal dialysis, including: (1) hemodialysis (at facility or at home); (2) transplantation; and that each of these options involves certain risks and consequences, as reviewed and discussed with my attending physician.

I understand that in addition to seeing my personal physician on a regular basis, I will be required to visit the Hospital at least once per month for evaluation by the Hartford Hospital Home Dialysis Team.

I will immediately notify my physician of any adverse reactions or problems I may have with regard to these peritoneal dialysis treatments.

I authorize repeated peritoneal dialysis treatments, unless I specifically revoke this consent. This consent will be renewed on or about on an annual basis.

I have read this consent and fully understand its contents. I have had a chance to have my questions answered in words I can understand. I hereby execute this consent form freely and with full acceptance and know of the contents in it. I also understand that this is a legal document.

Witness
Signature _____ Date _____

Patient or Legally
Authorized
Representative _____ Date _____

Physician
Signature _____ Date _____