NEAR EAST UNIVERSITY HOSPITAL

PATIENT INFORMATION AND CONSENT FORM FOR FLUID ASPIRATION FROM THE PLEURA (THORACENTESIS)

Unit Name		**Date**	
Patient's Full Name		**Protocol No**	
Date of Birth		**Early Diagnosis**	

Dear Patient/Legal Representative,

You have the right to be informed about your/your patient's health condition, any proposed medical, surgical, or diagnostic procedures, as well as their alternatives, benefits, risks, and potential harms. You also have the right to accept or decline these procedures or to stop them at any stage.

This document, which we ask you to read, is not intended to alarm you or dissuade you from undergoing the proposed medical interventions. Instead, it is prepared to provide you with the necessary information to help you decide whether to consent to the procedures and to obtain your approval.

I have been informed, as explained by my doctor, that in order to diagnose the disease causing my symptoms, it is necessary to perform a thoracentesis, which involves removing fluid accumulated between the pleural layers of the lungs. I understand that analyzing this fluid will contribute to the diagnosis and treatment of my condition, but that further examination may be required if a definitive diagnosis cannot be made. I have also learned that my doctor may need to conduct certain blood tests (to assess bleeding risk), as well as a chest X-ray or chest computed tomography (CT) evaluation before the procedure. have been informed that at the start of the procedure, my skin will be cleaned with an antiseptic (microbe-killing) solution, a local anesthetic will be applied to the area where the needle will be inserted, and after the fluid sample is obtained with the needle, a chest X-ray may be performed for monitoring purposes. My doctor has explained the reasons for using or not using ultrasound during this procedure.

I have been informed that this procedure carries certain risks, including the possibility of lung collapse (with a risk of 11%). If this occurs, my doctor may need to insert a tube between the ribs to remove air. This situation may require a longer hospital stay and treatment. Additionally, I was informed of the risks of coughing, chest pain, fainting, infection in the space around the lungs, coughing up blood (hemoptysis), very rarely damage to nearby tissues (such as the liver or spleen), and a very low risk of bleeding at the needle insertion site, fluid accumulation under the skin, bleeding in the space between the ribs and the lung, air embolism (air bubbles entering the blood vessels from the lungs), and related emergency surgical intervention.

If I have been given medication before the procedure, which may cause drowsiness, I was advised not to drive home. If I experience a feeling of shortness of breath upon returning home, I should go back and seek emergency care. *(This statement is written to inform patients undergoing the procedure in the outpatient clinic.)*

All required fields have been completed before signing.

Name of the proposed procedure	**Thoracentesis (Fluid Aspiration from the Pleura)**			
	☐	Right side	☐	Left side
	☐	Ultrasound used	☐	Ultrasound not used

I have read the information described above / my relative read it to me and I was informed by the doctor whose signature is below. I have been informed about the name, purpose, risks, complications, and potential additional treatment requirements of the procedure to be performed. I was given sufficient time to ask questions and make a decision regarding this medical procedure, and a copy of this patient consent form was provided to me. I was informed that the outcomes of this intervention might not be successful. Without any further explanation, under no pressure, and with full awareness, I consent to this procedure.

In the event that I lose consciousness or become unable to give consent during my diagnosis and treatment, I authorize the person named ……. to make decisions and receive all necessary information regarding my treatment (The person authorized by the patient must sign as the patient's representative/legal representative).

…… [Write "I HAVE READ, UNDERSTOOD, AND ACCEPT" in your own handwriting]

Patient's Full Name (in handwriting)	**Signature**	**Date/Time**
Name of Patient's Representative/Legal Representative (in handwriting) *NOTE: The signature of the representative/legal representative is required if the patient is unable to give consent.*	**Signature**	**Date/Time**
Doctor's Name (in handwriting)	**Signature**	**Date/Time**

Notes:

1. If the patient is under 18 years old, unconscious, or unable to sign, consent is given by a representative.
2. This form is completed in 2 copies; one copy remains with the patient.