

# CONSENT FORM

for

## UROLOGICAL SURGERY

(Designed in compliance with  consent form 1)

### PATIENT AGREEMENT TO INVESTIGATION OR TREATMENT

#### Patient Details or pre-printed label

Patient's NHS Number or Hospital number	
Patient's surname/family name	
Patient's first names	
Date of birth	
Sex	
Responsible health professional	
Job Title	
Special requirements <i>e.g. other language/other communication method</i>	

Patient identifier/label

<b>Name of proposed procedure</b> (Include brief explanation if medical term not clear)	<b>ANAESTHETIC</b>
<b>DA VINCI ROBOTIC ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY</b> REMOVAL OF THE WHOLE PROSTATE GLAND, SEMINAL VESICALS AND DRAINING LYMPH NODES, IF NECESSARY, FOR CANCER AS WELL AS TYING OF THE VAS DEFERENS. IT IS PERFORMED VIA SEVERAL KEYHOLE INCISIONS TO INTRODUCE A TELESCOPE AND INSTRUMENTS RATHER THAN THE MORE CONVENTIONAL INCISION. THE LAPAROSCOPIC INSTRUMENTS ARE HELD IN ROBOTIC ARMS CONTROLLED BY THE SURGEON	- GENERAL/REGIONAL - LOCAL - SEDATION

**Statement of health professional** (To be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy) I have explained the procedure to the patient. In particular, I have explained:

**The intended benefits**

TO TREAT LOCALISED PROSTATE CANCER

**Serious or frequently occurring risks** including any extra procedures, which may become necessary during the procedure. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. Please tick the box once explained to patient

COMMON

- TEMPORARY INSERTION OF A BLADDER CATHETER AND WOUND DRAIN
- HIGH CHANCE OF IMPOTENCE DUE TO UNAVOIDABLE NERVE DAMAGE
- NO SEMEN IS PRODUCED DURING AN ORGASM CAUSING SUB FERTILITY
- TEMPORARY SHOULDER TIP PAIN OR ABDOMINAL BLOATING

OCCASIONAL

- BLOOD LOSS REQUIRING TRANSFUSION OR REPEAT SURGERY, OR CONVERSION TO OPEN SURGERY
- URINARY INCONTINENCE TEMPORARY OR PERMANENT REQUIRING PADS OR FURTHER SURGERY
- DISCOVERY THAT CANCER CELLS ALREADY OUTSIDE PROSTATE NEEDING OBSERVATION OR FURTHER TREATMENT
- FURTHER TREATMENT AT A LATER DATE IF REQUIRED INCLUDING RADIOTHERAPY OF HORMONAL THERAPY

RARE

- ANAESTHETIC OR CARDIOVASCULAR PROBLEMS POSSIBLY REQUIRING INTENSIVE CARE ADMISSION (INCLUDING CHEST INFECTION, PULMONARY EMBOLUS, STROKE, DEEP VEIN THROMBOSIS, HEART ATTACK AND DEATH.)
- PAIN, INFECTION OR HERNIA IN AREA OF INCISION
- RECTAL INJURY, VERY RARELY NEEDING TEMPORARY COLOSTOMY
- CONVERSION TO OPEN SURGERY OR STANDARD LAPAROSCOPIC SURGERY
- COMPARTMENT SYNDROME - SWELLING OF TISSUES IN LEG REQUIRING URGENT DECOMPRESSION SURGERY
- RECOGNISED INJURY TO OTHER ORGANS OR BLOOD VESSELS REQUIRING CONVERSION TO OPEN SURGERY

ALTERNATIVE THERAPY: WATCHFUL WAITING, RADIOTHERAPY, BRACHYTHERAPY, HORMONAL THERAPY OR OPEN SURGERY OR TRADITIONAL LAPAROSCOPIC SURGERY

**A blood transfusion** may be necessary during procedure and patient agrees **YES or NO**

Signature of Health Professional	Job Title
Printed Name	Date

The following leaflet/tape has been provided

**Contact details** (if patient wishes to discuss options later)

**Statement of interpreter** (where appropriate) I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signature of interpreter:

Print name:

Date:

Copy (i.e. page 3) accepted by patient: yes/no (please ring)

Patient identifier/label

## Patient Copy

<b>Name of proposed procedure</b> (Include brief explanation if medical term not clear)	<b>ANAESTHETIC</b>
<b>DA VINCI ROBOTIC ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY</b> REMOVAL OF THE WHOLE PROSTATE GLAND, SEMINAL VESICALS AND DRAINING LYMPH NODES, IF NECESSARY, FOR CANCER AS WELL AS TYING OF THE VAS DEFERENS. IT IS PERFORMED VIA SEVERAL KEYHOLE INCISIONS TO INTRODUCE A TELESCOPE AND INSTRUMENTS RATHER THAN THE MORE CONVENTIONAL INCISION. THE LAPAROSCOPIC INSTRUMENTS ARE HELD IN ROBOTIC ARMS CONTROLLED BY THE SURGEON	- GENERAL/REGIONAL - LOCAL - SEDATION

**Statement of health professional** (To be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy) I have explained the procedure to the patient. In particular, I have explained:

**The intended benefits**

TO TREAT LOCALISED PROSTATE CANCER

**Serious or frequently occurring risks** including any extra procedures, which may become necessary during the procedure. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. Please tick the box once explained to patient

**COMMON**

- TEMPORARY INSERTION OF A BLADDER CATHETER AND WOUND DRAIN
- HIGH CHANCE OF IMPOTENCE DUE TO UNAVOIDABLE NERVE DAMAGE
- NO SEMEN IS PRODUCED DURING AN ORGASM CAUSING SUB FERTILITY
- TEMPORARY SHOULDER TIP PAIN OR ABDOMINAL BLOATING

**OCCASIONAL**

- BLOOD LOSS REQUIRING TRANSFUSION OR REPEAT SURGERY OR CONVERSION TO OPEN SURGERY
- URINARY INCONTINENCE TEMPORARY OR PERMANENT REQUIRING PADS OR FURTHER SURGERY
- DISCOVERY THAT CANCER CELLS ALREADY OUTSIDE PROSTATE NEEDING OBSERVATION OR FURTHER TREATMENT
- FURTHER TREATMENT AT A LATER DATE IF REQUIRED INCLUDING RADIOTHERAPY OF HORMONAL THERAPY

**RARE**

- ANAESTHETIC OR CARDIOVASCULAR PROBLEMS POSSIBLY REQUIRING INTENSIVE CARE ADMISSION (INCLUDING CHEST INFECTION, PULMONARY EMBOLUS, STROKE, DEEP VEIN THROMBOSIS, HEART ATTACK AND DEATH.)
- PAIN, INFECTION OR HERNIA IN AREA OF INCISION
- RECTAL INJURY, VERY RARELY NEEDING TEMPORARY COLOSTOMY
- CONVERSION TO OPEN SURGERY OR STANDARD LAPAROSCOPIC SURGERY
- COMPARTMENT SYNDROME - SWELLING OF TISSUES IN LEG REQUIRING URGENT DECOMPRESSION SURGERY
- RECOGNISED INJURY TO OTHER ORGANS OR BLOOD VESSELS REQUIRING CONVERSION TO OPEN SURGERY

ALTERNATIVE THERAPY: WATCHFUL WAITING, RADIOTHERAPY, BRACHYTHERAPY, HORMONAL THERAPY OR OPEN SURGERY OR TRADITIONAL LAPAROSCOPIC SURGERY

**A blood transfusion** may be necessary during procedure and patient agrees **YES** or **NO** (Ring)

<b>Signature of Health Professional</b>	<b>Job Title</b>
<b>Printed Name</b>	<b>Date</b>

The following leaflet/tape has been provided

Contact details (if patient wishes to discuss options later)

Statement of interpreter (where appropriate) I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signature of interpreter:

Print name:

Date:

Patient identifier/label

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

- I agree**
- to the procedure or course of treatment described on this form.
  - to a blood transfusion if necessary
  - that any tissue that is normally removed in this procedure could be stored and used for medical research (after the pathologist has examined it) rather than simply discarded. PLEASE TICK IF YOU AGREE
- I understand**
- that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
  - that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)
  - that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
  - about additional procedures which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

\_\_\_\_\_

Signature of Patient:		Print please:	Date:
-----------------------	--	---------------	-------

**A witness should sign** below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here. (See DOH guidelines).

Signed \_\_\_\_\_  
 Date \_\_\_\_\_  
 Name (PRINT) \_\_\_\_\_

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance). On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature of Health Professional	Job Title
Printed Name	Date

**Important notes: (tick if applicable)**

- . See also advance directive/living will (eg Jehovah's Witness form)
- . Patient has withdrawn consent (ask patient to sign/date here)