Print this Document

Before completing consent please read "Guidance For Health Professionals" for consent form 1 provided on the CD

Click here to read Guidelines (under the section called New Department of Health "Guidelines to Consent" page 40)

CONSENT FORM

for

UROLOGICAL SURGERY

(Designed in compliance with DH Department of Health 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 *e.g. other language/other communication method*	

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure **(Include brief explanation if medical term not clear)**	**ANAESTHETIC**
EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY ESWL **SIDE.....** THIS INVOLVES THE ADMINISTRATION OF SHOCKWAVES THROUGH THE SKIN TO FRAGMENT URINARY TRACT STONES INTO SMALL ENOUGH FRAGMENTS TO PASS NATURALLY	- **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 URINARY TRACT STONES

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
- ❑ BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER PROCEDURE
- ❑ PAIN IN THE KIDNEY AS SMALL FRAGMENTS OF STONE PASS AFTER FRAGMENTATION
- ❑ URINARY TACT INFECTION FROM BACTERIA RELEASED FROM THE STONE WHEN FRAGMENTED NEEDING ANTIBIOTIC TREATMENT

OCCASIONAL
- ❑ STONE WILL NOT BREAK AS TOO HARD REQUIRING AN ALTERNATIVE TREATMENT
- ❑ REPEATED ESWL TREATMENTS MAY BE REQUIRED
- ❑ RECURRENCE OF STONES

RARE
- ❑ KIDNEY DAMAGE (BRUISING) OR INFECTION NEEDING FURTHER TREATMENT
- ❑ STONE FRAGENTS OCCASIONNALY GET STUCK IN THE TUBE BETWEEN THE KIDNEY AND THE BLADDER REQUIRING HOPSPITAL ATTENDANCE AND SOMETIMES SURGERY TO REMOVE THE STONE FRAGMENT
- ❑ SEVERE INFECTION REQUIRING INTRAVENOUS ANTIBIOTICS AND SOMETIMES DRAINAGE OF THE KIDNEY BY A SMALL DRAIN PLACED THROUGH THE BACK INTO THE KIDNEY

ALTERNATIVE THERAPY: TELESCOPIC SURGERY, OPEN SURGERY OR OBSERVATION TO ALLOW SPONTANEOUS PASSAGE

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

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

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY ESWL **SIDE.....** THIS INVOLVES THE ADMINISTRATION OF SHOCKWAVES THROUGH THE SKIN TO FRAGMENT URINARY TRACT STONES INTO SMALL ENOUGH FRAGMENTS TO PASS NATURALLY	- **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 URINARY TRACT STONES

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
- ❑ BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER PROCEDURE
- ❑ PAIN IN THE KIDNEY AS SMALL FRAGMENTS OF STONE PASS AFTER FRAGMENTATION
- ❑ URINARY TACT INFECTION FROM BACTERIA RELEASED FROM THE STONE WHEN FRAGMENTED NEEDING ANTIBIOTIC TREATMENT

OCCASIONAL
- ❑ STONE WILL NOT BREAK AS TOO HARD REQUIRING AN ALTERNATIVE TREATMENT
- ❑ REPEATED ESWL TREATMENTS MAY BE REQUIRED
- ❑ RECURRENCE OF STONES

RARE
- ❑ KIDNEY DAMAGE (BRUISING) OR INFECTION NEEDING FURTHER TREATMENT
- ❑ STONE FRAGENTS OCCASIONNALY GET STUCK IN THE TUBE BETWEEN THE KIDNEY AND THE BLADDER REQUIRING HOPSPITAL ATTENDANCE AND SOMETIMES SURGERY TO REMOVE THE STONE FRAGMENT
- ❑ SEVERE INFECTION REQUIRING INTRAVENOUS ANTIBIOTICS AND SOMETIMES DRAINAGE OF THE KIDNEY BY A SMALL DRAIN PLACED THROUGH THE BACK INTO THE KIDNEY

ALTERNATIVE THERAPY: TELESCOPIC SURGERY, OPEN SURGERY OR OBSERVATION TO ALLOW SPONTANEOUS PASSAGE

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

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:

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.

I have been told

- 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) ...../.....