

Consent Form 1 – Patient Agreement to investigation or treatment

AFFIX PATIENT LABEL OR WRITE PATIENT DETAILS HERE:

Name:.....
 DIS:.....
 D.O.B:.....

Responsible health professional.....
 Job Title:.....
 Special Requirements:.....

 (eg: other language/other communication method)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)Surgical operation to remove pregnancy remains from within the uterus (womb).....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy, and preferably capable of performing procedure themselves)

I have explained the procedure to the patient with other possible alternatives. In particular, I have explained:
 The cervix (neck of the womb) may need to be dilated (opened) and the pregnancy remains removed. Tablets or pessaries may be given first to make the cervix softer and the operation safer.

The intended benefits: To remove any pregnancy remains from within the womb.

Frequent risks:

- Bleeding that lasts for up to two weeks is very common but heavy bleeding is uncommon (1-3 in 1000 women) and in that 1-3 in 1000 women, they may require a blood transfusion.
- Need for repeat procedure if all the pregnancy remains are not removed, up to 40 in 1000 women (common)
- Pelvic infection, 40 in 1000 women (common)
- Development of intrauterine adhesions, 190 in 1000 women (common)

Serious risks:

- Perforation of the womb up to 1 in 1000 women (uncommon)
- Significant tear of the neck of the womb, less than 0.1 in 1000 women (rare)

Any extra procedures which may become necessary during the procedure:

Blood transfusion

Other procedure Laparoscopy (keyhole surgery) to investigate for any suspected injury, if there is perforation of the womb.
 Laparotomy (open surgery) to repair any injury

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.

The following leaflet/s have been provided.....

This procedure will involve:

General and/or regional anaesthesia Local anaesthesia Sedation

Signed:..... Date:.....

Name (PRINT):..... Job Title:.....

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 she can understand

Signed..... Date:.....

Name (PRINT):.....

Copy accepted by patient: Yes/No (Please ring)

Statement of patient:

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy 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

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will however have appropriate experience.

I understand 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 that have general or regional anaesthesia.

I understand 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.

.....
.....
.....

Patients signature..... Date.....

Name (PRINT).....

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.

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 signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that she has no further questions/concerns and wishes the procedure to go ahead.

Signed..... Date.....

Name (PRINT)..... Job title.....

Important notes: (tick if applicable)

- See also advance directive/living will (e.g Jehovah’s witness form)
- Patient has withdrawn consent (ask patient to sign/date here)