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

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

EXPLORATION OF SCROTUM FOR ?TORSION +/- ORCHIDECTOMY IF REQUIRED

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 *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
EXPLORATION OF SCROTUM FOR SUSPECTED TORSION OF TESTIS **SIDE** . THIS INVOLVES THE EXAMINATION OF THE TESTIS VIA A SCROTAL INCISION. UNTWISTING OF TESTIS FIXATION OF BOTH TESTES IN SCROTUM TO PREVENT TWISTING IN THE FUTURE	- 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 RELIEVE OBSTRUCTION OF BLOOD SUPPLY TO TESTIS AND TREAT TESTICULAR ABNORMALITY

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
- ❑ FIXATION OF BOTH TESTES IF TORSION IS DISCOVERED VIA SAME INCISION
- ❑ I AGREE TO REMOVAL OF TESTIS DURING SURGERY IF DAMAGE CAUSED BY TWISTING IS THOUGHT IRREVERSIBLE

OCCASIONAL
- ❑ YOU MAY BE ABLE TO FEEL THE STITCH USED TO FIX THE TESTIS
- ❑ BLOOD COLLECTION AROUND TESTES WHICH RESOLVES SLOWLY OR REQUIRES SURGICAL REMOVAL.
- ❑ POSSIBLE INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

RARE
- ❑ LOSS OF TESTICULAR SIZE OR ATROPHY IN FUTURE IF TESTIS IS SAVED
- ❑ NO GUARANTEE OF FERTILITY

ALTERNATIVE THERAPY: OBSERVATION RISKS LOSS OF TESTIS.

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

Signature of Health Professional	Job Title
Printed Name	Date

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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) ...../.....