

Consent form 1

Patient agreement to investigation or treatment

For staff use only:
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:
(Use hospital identification label)

Responsible health professional/job title

Special requirements
(For example other language/other communication method)

Name of proposed procedure or course of treatment

Haemophilia treatment with clotting factors and viral surveillance.

- Infusion of plasma derived clotting factor. (Product name.....)
- Infusion of recombinant clotting factor. (Product name
- Viral surveillance

Statement of health professional

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have discussed the procedure with the patient and explained the following

• **How it will be performed for them.**

- Demand Intravenous Therapy
- Prophylactic Intravenous Therapy
- Continuous infusion

• **The intended benefits of the procedure.**

- Prevention of bleeding episodes
- Reduction of joint damage (Haemophilic joint arthropathy)
- Normalisation of clotting during operative procedures
- Prevention of life threatening bleeding episodes

• **Serious or frequently occurring risks**

- Neutralising antibodies (Inhibitors)
- Anaphylaxis
- Phlebitis
- Specific to the patient

• **Any extra procedures that might become necessary during the procedure**

If an inhibitor develops, you may be required to undergo intensive therapy (Immune tolerance). I have discussed what the treatment / 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 information leaflet has been provided:

This procedure will involve: Topical / local anaesthesia

Health professional's signature:Date:

Name (PRINT):Job title:

Contact details (if patient wishes to discuss details later) Haemophilia Centre Tel. 01223 257039

I have offered the patient information about the procedure but s/he has declined information.

Statement of the interpreter (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature Date:

Name (PRINT):

For staff use only: Surname: First names: Date of birth: Hospital no: Male/Female: (Use hospital identification label)

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. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

Please read the following:

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.
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 that **I do not wish, without further discussion, to be carried out.**

I understand that any tissue (including blood) removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

I understand that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

I understand that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

Please tick boxes to indicate you either agree/disagree to the three points below. Yes No

I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** **If you wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

Patient's signature: **Date:**

Name (PRINT):

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

Witness' signature: **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 **Date:**

Name (PRINT): **Job Title:**

Important notes: (tick if applicable)

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

Copy accepted by patient: yes / no (please circle)