

Patient agreement to investigation or treatment

Subcutaneous injection of DDAVP (Octostim, desmopressin acetate)

Authors: Haemophilia Centre

Brief description:

- You have been recommended a synthetic drug called DDAVP for your blood clotting disorder. DDAVP is a hormone called vasopressin and is not a blood product.
- The DDAVP drug is used to prevent excessive bleeding during surgical procedures, dental work and minor bleeds for patients with mild haemophilia A (levels > 5%), von Willebrand’s disease and some other rarer bleeding disorders. In the majority of individuals, when it is given, it can increase the levels of factor VIII (FVIII) and von Willebrand factor (vWF) 3 to 5 times above the patient’s normal level. This happens within 30-60 minutes of injection. The levels may remain elevated for 8 to 10 hours.
- You might be given a test dose of Desmopressin (DDAVP) to assess its effectiveness in you before it is required as a treatment. This will involve a blood test before and after this test dose of DDAVP.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.
- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke’s website: <http://www.addenbrookes.org.uk/consent>
- Guidance for health professionals can be found on the Addenbrooke’s intranet site <http://nww.addenbrookes.nhs.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

For staff use:

Does the patient have any special requirements? (eg requires an interpreter or other additional communication method)

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About DDAVP

Before taking DDAVP we will take special precautions with patients who:

- Are over 65 years unless otherwise fit and healthy
- Have a past history of vascular disease, myocardial infarction, high blood pressure or stroke.
- Have type 2 von Willebrand unless a trial of therapy has proved it to be effective (especially type 2B).

Before your procedure

- When you arrive for the procedure, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free to discuss any concerns you might have at any time.
- You will be asked if you are taking any tablets or other types of medication - these might be ones prescribed by a doctor or bought over the counter in a health food shop. It helps us if you bring details with you of anything you are taking (eg bring the packaging with you). Some anti-depressants, chlorpromazine and carbamazepine may increase fluid retention.

During the procedure itself

- DDAVP may be given subcutaneously (under the skin), intravenously (into a vein) or intranasally (inhaled with a metered spray in to the nostril). Usually only one dose is given. A repeat dose may be given to adults 12 to 24 hours later if required. If there is not an adequate response to DDAVP we may need to administer an intravenous plasma derived or recombinant clotting factor.

After the procedure (operation/treatment)

- Do not drink more fluid than you would normally (adults 1.5 to 2 litres a day).

Intended benefits of the procedure

- The treatment of bleeding episodes in mild and moderate haemophilia.
- The normalisation or enhancement of clotting during operative procedures.

Who will perform my procedure?

- This procedure will be performed by a Haemophilia nurse or by the ward nursing staff.

Alternative procedures that are available

- Other treatments can be given such as Antifibrinolytic product eg tranexamic acid, plasma derived /recombinant clotting factor, blood Tx or FFP. These will be discussed with you before the procedure.

Serious or frequently occurring risks

- Fluid retention with hyponatraemia (low salt) leading to convulsions.
- Headache and facial flushing.
- Transient fall in blood pressure.
- Stomach pains and nausea.

Information and support

- You might be given some additional patient information before or after the procedure eg leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including the Haemophilia Nurse Specialists.
- Haemophilia Centre Telephone 01223 257039 (Mon to Fri 8.30am to 4.30pm).
- Haemophilia Society – www.haemophilia.org.uk.

This document is also available in other languages, large print and audio format upon request – 01223 216032

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Cantonese

આ દસ્તાવેજ વિનંતી કરવાથી બીજી ભાષાઓ, મોટા છાપેલા અક્ષરો અથવા ઓડિઓ રચનામાં પણ મળી રહેશે.

Gujarati

A richiesta questo documento è anche disponibile in altre lingue, a caratteri grandi e in formato audio.

Italian

ئەم بەلگەيە ھەر ھەروەھا بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەوێت

Kurdish

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

Urdu

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
(eg other language/other communication method)

Name of proposed procedure or course of treatment

Subcutaneous injection of DDAVP (Octostim, desmopressin acetate)

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 explained the procedure to the patient. In particular, I have explained:

- How it will be performed
- The intended benefits of the procedure
- Any serious or frequently occurring risks including those specific to the patient

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- Any extra procedures that might become necessary during the procedure
- Blood transfusion
- Other procedure (please specify)

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:
..... Version/Date/Ref:

Health professional's signature **Date:**

Name (PRINT): Job title:

Contact details (if patient wishes to discuss details later)

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

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)

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):

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

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 described 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 tick boxes to indicate you understand and either agree/disagree to the statements below.

- | | Yes | No |
|---|--------------------------|--------------------------|
| I agree to the procedure (or course of treatment) described on this form. | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience. | <input type="checkbox"/> | <input type="checkbox"/> |
| I agree that any tissue (including blood) removed as part of the procedure or treatment may be used for diagnosis and audit, stored or disposed of as appropriate and in a manner regulated by appropriate, ethical, legal and professional standards. | <input type="checkbox"/> | <input type="checkbox"/> |
| I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used for the following purposes that could benefit other patients. | <input type="checkbox"/> | <input type="checkbox"/> |
| Teaching | <input type="checkbox"/> | <input type="checkbox"/> |
| Research which may include genetic research | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards. | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |

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Patient's own 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's own 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:**.....