

Patient agreement to investigation or treatment

Total gastrectomy

Authors: Cambridge Upper Gastro-Intestinal Surgical Unit

Brief description:

- You have been advised to have surgery to remove all of the stomach – termed a total gastrectomy. Gastrectomies can be performed for several conditions of the stomach particularly for patients who have stomach cancer or precancerous conditions but sometimes for non-cancerous conditions such as bleeding or narrowing of the stomach.
- 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.

Please bring this form with you to hospital

- 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:

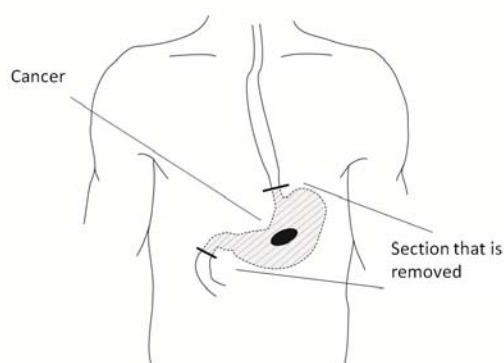
Does the patient have any special requirements? (eg requires an interpreter or other additional communication method)

.....
.....

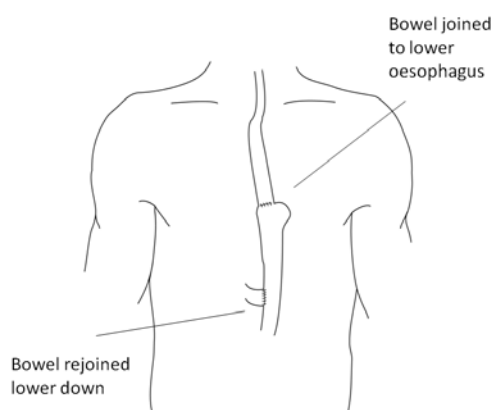
About Total Gastrectomy

A total gastrectomy involves removing the stomach in its entirety. The lower oesophagus (gullet) is then joined to the bowel so that you are able to eat. The glands, nerves and blood vessels adjacent to the stomach are also removed. If a total gastrectomy is performed for cancer, it is an advantage to remove the glands as they may contain cancerous cells. The diagram below may help you understand what is done in this procedure.

Before total gastrectomy



After total gastrectomy



Before your procedure

- Most patients attend a pre-admission clinic, when you will meet a member of the surgical team.
- At this clinic, 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 (for example, bring the packaging with you).
- This procedure involves the use of general anaesthesia. See below for further details about this type of anaesthesia.
- Most people who have this type of procedure will need to stay in hospital overnight in preparation for the operation the next day.

During the procedure (operation/treatment) itself

- Before your procedure, you will be given the necessary anaesthetic - see below for details of this.
- The surgery involves making a long incision under your ribcage to access the stomach area, allowing removal of the stomach. A segment of the bowel is joined to the lower oesophagus. Lower down, the bowel is rejoined. Your surgeon will explain what the new 'plumbing' will be like.

After the procedure (operation/treatment)

- You will wake up in the recovery room after your operation. You might have an oxygen mask on your face to help you breathe. You might also wake up feeling sleepy.
- After this procedure, most people will have a small, plastic tube in one of the veins of their arm. This might be attached to a bag of fluid (called a drip), which provides your body with fluid until you are well enough to eat and drink by yourself.
- While you are in the recovery room, a nurse will check your pulse and blood pressure regularly. When you are well enough to be moved, you will be taken to a ward.
- Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.
- **Drain tubes:** You may have some tubes in your abdomen and down your nose. The purpose of these is to prevent the accumulation of body fluids that may lead to infection. Usually drain tubes are kept in for three to seven days.
- **Getting around and about:** Generally, it is best to get out of bed as soon as you feel you can. If, on the first day, you cannot get out of bed, you will be encouraged to move your legs in bed to prevent blood clots forming.
- **When you can leave hospital:** People who have had a gastrectomy will probably stay as an inpatient for about 9 to 14 days. The time that you stay in hospital will depend on how quickly you recover from your operation, the type of operation, and your doctor's opinion.
- **When you can resume normal activities including work:** Most people who have had this procedure can resume normal activities six to eight weeks after leaving hospital. This will also depend on whether you are having other treatments. You might need to wait a little longer (i.e. three to six months) before resuming more vigorous activity. When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. Please ask your doctor for his/her opinion.
- **When do you have to come back for a check up?** We routinely give everyone a check up at two weeks in the outpatients department. Then we review you at three, six and twelve months from the date of your surgery and then yearly thereafter, for five years. When the stomach is removed it is sent to the laboratory for examination. Whether lymph glands are involved or not, is very important in providing some indication as to whether surgery is likely to have been curative or not. You will have a detailed discussion with your consultant about this either before you leave the hospital or when you are seen in the outpatients department.
- **Anaemia:** The stomach is important in the absorption of iron and Vitamin B12. These are required for the formation of red blood cells. If you become depleted in iron or B12 you may become anaemic (low blood count). If this occurs it usually happens months to years after the surgery. Because of this risk your general practitioner will check your blood count every six months or so. If the levels of the B12 or iron are low supplements can be given. Iron tablets are available and B12 injections can be given as a simple injection every three months.

Intended benefits of the procedure

- The aim of the surgery is to remove the cancer or abnormality– completely if possible. For cancer operations, surgery gives the best chance of cure, but the treatment may need to be combined with chemotherapy and/or radiotherapy.

Who will perform my procedure?

- This procedure will be performed by a Consultant Surgeon or by a senior surgeon in training under the supervision of a Consultant Surgeon.

Alternative procedures that are available

- Currently, the only known way of curing stomach cancer includes this type of surgery. Often other treatments, such as chemotherapy, are combined with surgery. These are tailored to the individual patient. Cancers involving only the mucosa (stomach lining) can sometimes be safely removed by an endoscopy (telescope passed through the mouth into the stomach) under sedation. This technique is called Endoscopic Mucosal Resection or EMR.

Serious or frequently occurring risks

- **Anastomotic leak** – This is the most important, serious complication following a total gastrectomy. Fortunately it is rare (approx 5% risk). Where the gastrointestinal tract is rejoined after an operation is called the anastomosis. Surgeons take great care and time in constructing a water tight anastomosis that will not leak. However, in rare cases the anastomosis does not remain water tight. This is often because of a poor blood supply rather than any particular problem with the surgery. If a leak does occur, there is a significant risk of infection and you will require antibiotics and possibly a fine drain tube to be inserted (under local anaesthetic) next to the anastomosis to get rid of any excess fluid or infection. With an anastomotic leak you usually are not permitted to take anything by mouth as this may worsen the leak. Most anastomotic leaks are very small (pin head size) and resolve spontaneously after five to seven days, without too many problems. In rare cases, patients can become very ill and need to be transferred back to the intensive care unit or require further surgery.
- **Chest infection** – Major surgery carries with it a risk of developing an infection in the lungs or pneumonia and it is quite common following this procedure (15%). This is usually because you are a little immobile and not breathing deeply following surgery, resulting in the lower part of the lungs becoming stagnant. Chest infections are treated with antibiotics and physiotherapy. It is very important that you get up and moving as soon as possible and work closely with the nursing staff or physiotherapist in making sure you are taking regular, deep breaths. You will be given deep breathing exercises to undertake. The risk of developing a chest infection is greatly increased if you smoke cigarettes (particularly within three months of surgery).

- **Pleural effusion** – Fluid that collects between the lung and the chest wall is called a pleural effusion. This sometimes develops following surgery and is in many ways the body's normal reaction to surgery. If fluid does, however, accumulate as a pleural effusion it may need to be specifically drained. This is usually done under local anaesthetic either on the ward or by our colleagues in the X ray department.
- **Complications relating to the heart** – Major surgery places considerable stress on the body and there is a small risk of a problem relating to the heart. This may take two forms and varies from very minor to severe. Firstly, the heart may develop an abnormal rhythm (usually beating excessively quickly). You may notice a fluttery feeling (palpitations) in the chest or nothing at all. Usually, simple measures such as balancing the body's salt concentrations, or administering medications resolve these problems. Secondly and more seriously, suffering a heart attack (damage to the heart muscle) is possible. Because of these risks you are very closely monitored (including continuously recording the rhythm of the heart) for the first five days following your surgery. Therefore, if a problem arises it can usually be treated early and effectively. The risk of developing a heart problem is increased if you have a history of heart problems, smoke cigarettes (particularly within three months of surgery) or have other risk factors for heart disease.
- **Deep vein thrombosis (DVT) and pulmonary embolus** - All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. In the worst case a clot in the leg can break off and travel to the lung (pulmonary embolism). This can significantly impair your breathing. To prevent these problems around the time of your operation and following your operation we give you some special injections to 'thin' the blood. We also ask you to wear compression stockings on your legs before and after surgery and also use a special device to massage the calves during the surgery. Moving about as much as you can, including pumping your calf muscles in bed or sitting out of bed as soon as possible reduce the risk of these complications.
- **Damage to the bowel (intestines)** - Any surgery inside the abdominal cavity is associated with a very small risk (less than 1 in 500 chance) of damaging other organs, such as the bowel. This is particularly the case if there has been previous surgery with scarring and structures are abnormally stuck to each other. If there is damage to the bowel it can almost always be repaired at the time. If it is not noticed at the time and you later become unwell a second procedure may be required. This is a more serious situation.
- **Damage to major blood vessels** - Any major surgery is associated with a small risk of bleeding from a major blood vessel. This is uncommon; however, if the surgery involves delicate procedures very close to major blood vessels there is a risk. If this were to occur the surgeon would take measures to stop the bleeding and it is possible you would require a blood transfusion.

- **Damage to the spleen** - During the operation, the small blood vessels between the spleen and the upper part of the stomach (fundus) are cut using special instruments that seal the blood vessels before they are divided. Very rarely, damage to the spleen can occur (1% risk) that results in bleeding. Most times, this is not serious and can be controlled simply, however, if the spleen were to sustain a more severe injury the spleen may have to be removed to prevent further bleeding. Removing the spleen normally has few complications. If your spleen is removed you will be given some vaccinations prior to leaving hospital. Additionally, you will be advised to stay on a low dose of preventative antibiotic for at least two years.
- **Bleeding** – This very rarely occurs after any type of operation. Your pulse and blood pressure are closely monitored after your operation as this is the best way of detecting this potential problem. If bleeding is thought to be happening, you may require a further operation to stop it. This can usually be done through the same scar(s) as your first operation. It is possible that you also may require a blood transfusion.
- **Wound haematoma** - Bleeding under the skin can produce a firm swelling of blood clot (haematoma), this may only become apparent several days after the surgery. It is essentially a bruise. This may simply disappear gradually or leak out through the wound without causing any major consequences to you.
- **Wound Infection** – This affect your scars. If the wound becomes red, hot, swollen and painful or if it starts to discharge smelly fluid then it may be infected. It is normal for the wounds to be a little sore, red and swollen as this is part of the healing process and represents the body's natural reaction to surgery. It is best to consult your doctor if you are concerned. A wound infection can happen after any type of operation. Simple wound infections are easily treated with a short course of antibiotics.
- **Deep Infection** – A rarer and more serious problem with infection is where an infection develops inside your tummy or chest cavity. This will often need a scan to diagnose, as there may be no obvious signs on the surface of your body. Fortunately, this type of problem will usually settle with antibiotics. Occasionally, it may be necessary to drain off infected fluid. This is most frequently performed under a local anaesthetic by our colleagues in the X ray department. In the worst case scenario a further operation is required to correct this problem.
- **Anastomotic stricture** - The join between your oesophagus and your small bowel ("anastomosis") can sometimes narrow down during its healing phase. A stricture is a technical term that simply means a narrowing. This narrowing can cause problems with swallowing, particularly with solid foods. If this happens you might need to have the join stretched gently to make it wider again. This can be done as an outpatient in the endoscopy unit under gentle sedation. Anastomotic strictures often are not apparent for at least several months after surgery and may not occur until one to two years later.

- **Scarring** – Any surgical procedure that involves making a skin incision carries a risk of scar formation. A scar is the body's way of healing and sealing the cut. It is highly variable between different people. All surgical incisions are closed with the utmost care, usually involving several layers of sutures. The sutures are almost always dissolvable and do not have to be removed. The larger an incision the more prominent it will be. Despite our best intentions, there is no guarantee that any incision (even those only 1-2 cm in length) will not cause a scar that is somewhat unsightly or prominent. Scars are usually most prominent in the first few months following surgery, however, tend to fade in colour and become less noticeable after a year or so.
- **Death** – All major surgery carries a risk of death related to the procedure and the anaesthetic. It is estimated that this risk of death with this procedure is 1-2%.
- **Other complications** – We have tried to describe the most common and serious complications that may occur following this surgery. It is not possible to detail every possible complication that may occur following any operation. If another complication that you have not been warned about occurs, we will treat it as required and inform you as best we can at the time. If there is anything that is unclear or risks that you are particularly concerned about, please ask.
- **Following discharge** – You will be given a copy of your discharge summary. If you experience any concerns requiring urgent medical advice please contact:

Nurse Specialist (Monday – Friday 09:00-17:00) on 01223 596383 or through switchboard 01223 245151 and ask for pager 154-348

Or

Ward D7 (Evenings/Weekends) on 01223 217303

Consequences of the operation

Eating and drinking:

- You will only have very small amounts of cold water to keep your mouth wet at first. We usually wait for about five days before we allow you to start drinking normally again. You will start by taking "clear fluids" which include water, squash/cordial, Bovril, black tea and coffee and a nutritional supplement called Fortijuce. Following this you will proceed to "free fluids" which are all liquids including milk based and strained soups without bits or lumps. You will also be able to take a supplement called Fortisip. Usually about seven to ten days after surgery you will be able to start on a very light diet (focusing on softer or mushy foods initially) in conjunction with nourishing drinks.
- One of the most noticeable things after this operation is that you will no longer be able to manage to eat the same amount of food as you used to. The only way of ensuring that you still get sufficient calories is to eat smaller amounts but more regularly. Where you may have been used to having three meals a day you will now need to adopt a small frequent meal pattern, ideally we advised five to six small snacks/meals per day with nourishing drinks. You may need to continue with nutritional supplements which your GP can prescribe.

- Weight loss is highly likely. Because the stomach has been removed, the storage capacity is greatly reduced so you will manage considerably less. You will feel full up quickly and will be uncomfortable if you try to eat any more. However after some weeks to months you will notice that you can eat a little more. Most patients report that their meal sizes are about 50% compared to before the operation. The dietitian will support you with this aspect of your recovery but everyone finds it difficult at first. Many patients, over a period of several months, adapt well to the new internal plumbing and can eat well.
- During your operation, the main nerve (vagus nerve) to the intestines has to be cut. This usually has some effects on the bowel function and is called "Dumping syndrome". One of the commonest effects is that you can have attacks of unexpected diarrhoea. This is sometimes associated with some discomfort or pain in the abdomen and sometimes dizziness and feeling very hot. It usually occurs shortly after eating and the effects normally disappear within an hour or so. Ordinarily, food is partially digested in the stomach and then released gradually into the intestines. Dumping syndrome occurs when the food you have eaten passes into your small intestine more rapidly as a consequence of the surgery. This does not affect everyone and those who experience it usually find that it improves with time. The dietitian can advise you on changes to your diet that can reduce these effects.

Your anaesthesia

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation.

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on; whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or done in an emergency. Please discuss any pre-existing medical condition with your anaesthetist.

- Very common and common side effects (1 in 10 or 1 in 100 people)
Feeling sick and vomiting after surgery, sore throat, dizziness, blurred vision, headache, itching, aches, pains and backache, pain during injection of drugs, bruising and soreness, confusion or memory loss.
- Uncommon side effects and complications (1 in 1000 people)
Chest infection, bladder problems, muscle pains, slow breathing (depressed respiration), damage to teeth, lips or tongue, an existing medical condition getting worse, awareness (becoming conscious during your operation).
- Rare or very rare complications (1 in 10,000 or 1 in 100,000)
Damage to the eyes, serious allergy to drugs, nerve damage, death, equipment failure.

Before your operation

Before your operation your anaesthetist will visit you in the ward, although occasionally this will happen in a pre-anaesthetic assessment clinic. If you are a day case patient it may not be until just before your operation. The anaesthetist who looks after you on the day of your operation is the one who is responsible for making the final decisions about your anaesthetic. He or she will need to understand about your general health, any medication that you are taking and any past health problems that you have had. Your anaesthetist will want to know whether or not you are a smoker, whether you have had any abnormal reactions to any of the drugs or if you have any allergies. They will also want to know about your teeth, whether you wear dentures, have caps or a plate. Your anaesthetist needs to know all these things so that he or she can assess how to look after you in this vital period. Your anaesthetist may examine your heart and lungs and may also prescribe medication that you will be given shortly before your operation, the pre-medication or 'pre-med'.

Pre-medication is the name given to medication (drugs) given to you some hours before your operation. These drugs may be given as tablets, injections or liquids (to children). They relax you and may send you to sleep. They are not always given. Do not worry if you do not have a pre-med, your anaesthetist has to take many factors into account in making this decision and will take account of your views on the topic if possible. Do not be worried about your anaesthetic. When your anaesthetist visits you before your operation, this is the time to ask all the questions that you may have, so that you can forget your fears and worries.

Before your operation you will usually be changed into a gown and wheeled to the operating suite into an anaesthetic room. This is an ante-room outside the theatre. The anaesthetist, his or her assistant and nurses are likely to be present. An intravenous line (drip) may be inserted. Monitoring devices may be attached to you, such as a blood pressure cuff or a pulse oximeter. A pulse oximeter is usually a little red light in a small box, which is taped to your finger. It shows how much oxygen you have in your blood and is one of the vital monitors that an anaesthetist uses during your operation to ensure that you remain in the best of health. You may be given some oxygen to breathe. It is common practice nowadays to allow a parent into the anaesthetic room with children: as the child goes unconscious, the parent will usually be asked to leave.

Epidural anaesthesia is one method of reducing pain following major abdominal or chest surgery and we have found it to be a most effective technique. An epidural is a very fine, hollow plastic tube that is placed between the vertebrae in your spine, so that it sits close to where the nerves enter the spinal cord. It is usually left in place for five days. Because of its location, anaesthetic medications in very low doses can be delivered directly to the important nerves. It has the advantage of providing very effective pain relief, without sedating you or risking other complications that large doses of pain relief may cause. An epidural works well by blocking the nerves that convey sensations of pain. There are risks associated with having an epidural, most importantly; there is a very small chance of damage to the important spinal nerves. In the worst case this can lead to a permanent impairment. Fortunately, this is extremely rare.

You will need a urinary catheter to be in place whilst you have an epidural as you will not be able to urinate on your own easily. Overall, we feel that for most patients, the significant benefits provided by an epidural vastly outweigh the very small risk of complications. Your anaesthetist will speak to you about having an epidural and talk to you about other options for controlling pain after your surgery.

During your operation

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you in the correct level of unconsciousness for the period of the surgery. Your anaesthetist is constantly aware of your condition and trained to respond. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement. If you have any other medical conditions, your anaesthetist will know of these from your pre-operative assessment and be able to treat them during surgery.

After your operation

After your operation your anaesthetist continues to monitor your condition carefully. You will probably be transferred to a recovery ward where specially trained nurses, under the direction of anaesthetists, will look after you. Your anaesthetist and the recovery nurses will ensure that all the anaesthetic effects are reversed and that you are closely monitored as you return to full consciousness. You may be given some oxygen to breathe in the recovery area, and may find that intravenous drips have been inserted whilst you are unconscious in theatre and that these will be replacing fluids that you might require. You will be given medication for any pain that you might feel, and systems, such as Patient Controlled Anaesthesia (PCA) may be set up to continue pain control on the ward.

You are likely to feel drowsy and sleepy at this stage. Some patients feel sick; others may have a sore throat related to the insertion of the breathing tube during surgery. During this time it is important that you relax as much as you can, breathe deeply, do not be afraid to cough, and do not hesitate to ask the nursing staff for any pain relief, and about any queries you may have. You are likely to have hazy memories of this time and some patients experience vivid dreams. Once you are fully awake you will be returned to the ward, and if you are a day patient will be allowed to go to the waiting area to fully recover before you are accompanied home. Do not expect to feel completely normal immediately!

Information and support

- You might be given some additional patient information before or after the procedure, for example 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 your surgeon, one of the senior trainees or the Oesophago-gastric cancer nurse specialist.

Consultant contact details

Mr Richard Hardwick	Consultant Upper GI Surgeon	Tel: 01223 217421
Mr Peter Safranek	Consultant Upper GI Surgeon	Tel: 01223 217421
Mr Chris Collins	Consultant Upper GI Surgeon	Tel: 01223 358024



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169

Help with this leaflet:

If you would like this information in another language, large print or audio format, please ask the department to contact Patient Information: 01223 216032 or patient.information@addenbrookes.nhs.uk

**Document history**

Authors	Cambridge Upper Gastrointestinal Unit
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
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Version number/Ref	2/CF196

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

Total gastrectomy

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 – treatment aiming to cure the cancer or tumour
 - Any serious or frequently occurring risks including those specific to the patient - bleeding, infection, leak, reoperation, chest infection, cardiac complications, DVT, PE, vascular or intestinal injury, inoperability, splenic injury, mortality (1-2%)
 - 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: Total gastrectomy
- Version/Date/Ref: 2/August 2011/CF196.....

This procedure will involve:

- General and/or regional anaesthesia Local anaesthesia Sedation

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. | | |
| 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 agree to the use of photography for the purpose of diagnosis and treatment. | <input type="checkbox"/> | <input type="checkbox"/> |
| I agree to anonymised photographs being used for medical teaching. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 having general or regional anaesthesia.) | <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"/> |

.....

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:**