Patient agreement to investigation or treatment

Surgical evacuation of retained products of conception (ERPOC) (for example: after a miscarriage)

Authors: Gynaecology Department

Brief description:

- Sadly your pregnancy has resulted in miscarriage. We are very sorry that this has happened. Miscarriage in early pregnancy is very common, with as many as one in four confirmed pregnancies ending this way.
- After a miscarriage, there can be some tissue and/or blood clot left in the uterus (womb). This tissue and/or blood clot may pass naturally or we can perform an operation to remove this or you can also have medication to empty the womb.
- You have chosen to have an operation to empty your womb or you may have been advised to do so by your doctor.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation). 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
- Remember, you can change your mind about having the procedure at any time.

For staff use:

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

....

....

About Evacuation of retained products of conception

The procedure is performed under a general anaesthetic (this will be explained further later in this leaflet). Generally you will be admitted onto the Day Surgery Unit for this at a planned time and date (Elective admission). Occasionally it is necessary for you to have this done sooner and you may stay on the Early Pregnancy Unit (on Daphne ward) or be admitted onto the in-patient Gynaecology Ward.

Before your procedure

- Most patients are seen on the Early Pregnancy Unit when you will meet one of the nurses and/or a doctor.
- At this time, 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 pharmacy. It helps us if you bring details with you of anything you are taking (for example: bring the packaging with you).
- You will need to starve for at least six hours prior to your procedure. The staff will advise you at what time to do this.
- This procedure is a day case procedure and most women are able to go home a few hours after the operation. Sometimes we can predict whether you will need to stay longer than usual – your doctor/nurse will discuss this with you before you decide to have the procedure.
- Sometimes you may be given medication called misoprostol to help the opening up of the cervix, if this has not already happened. Generally this is given as a vaginal pessary an hour before your operation.

What do I need to bring in with me?

- Bring some basic toiletries with you, such as a toothbrush and some sanitary towels.
- Bring a dressing gown and some slippers.
- Wear only a minimal amount of jewellery. Only small rings, which will be taped, are allowed into the theatre suite.
- Do not wear makeup, and ensure any nail polish is removed from your finger and toe nails.
- If you wear contact lenses, they will need to be removed prior to your going into theatre.

May I bring someone with me?

Yes. Your partner, friend or family member is welcome to stay with you for the day. However, there are **no** facilities to care for children on the unit, therefore please make your own arrangements for childcare before attending the hospital.

During the procedure itself

- Before your procedure, you will be given the necessary general anaesthetic - see below for details of this and the role of the anaesthetist in your care.
- Once you are asleep with the general anaesthetic, the gynaecologist inserts a speculum into your vagina so that the cervix (the opening of the uterus) can be seen. We then gently stretch open the cervix using some dilators, and pass a hollow tube through it. We then use some suction to remove the retained tissue and any blood clot. After emptying the womb by suction, the womb is usually explored with other instruments which can remove any tissue that may remain or confirm the womb is empty. These instruments include one called a curette which many women have heard about as it is often described as having a scrape. The procedure takes less than 15 minutes.

After the procedure

- As you have had a general anaesthetic 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 feeds 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 in addition to checking to see if you have had excessive vaginal bleeding. 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.
- **Eating and drinking**: After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe - this is usually as soon as you are awake enough. We also recommend you avoid any alcohol for the first 24 hours following the procedure as any effects will be enhanced by the anaesthetic.
- **Getting around and about**: After this procedure, we will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. Typically, you will be able to get up when you feel awake enough. If we think you will have problems getting about, we will arrange for extra assistance, such as nursing help and physiotherapy advice/exercises.
- **When you can leave hospital**: Most women are able to go home a minimum of four hours after the operation, on the same day. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion. You must have had something to eat and drink, been able to pass urine, have minimal pain and vaginal bleeding and have someone to take you home and be with you overnight.
- **When you can resume normal activities including work**: Most women prefer to take the following day off work, both for their emotional and physical recovery. You must not drive for 24 hours following general anaesthetic as the drugs may still be in your system. If you have another child at home we suggest you have another adult around to assist you as you may be sleepy.

Some women can take up to a week off work – you are able to self-certificate for up to five working days.

- **Emotional impact:** Women react in different ways to a miscarriage: some women come to terms with what has happened within a few weeks, others can take much longer. It is normal to feel tearful and sad, angry or even guilty. Losing a baby can be a very painful experience for partners too, and sometimes their grief is unacknowledged.
- **Special measures you need to take after the procedure**: If you have an ERPOC performed and your blood group is rhesus negative, we will give you an injection of anti-D immunoglobulin. This will help prevent antibodies forming and affecting later pregnancies.
- **Vaginal bleeding:** You may have some vaginal bleeding for one to two weeks following the procedure and we advise you to use sanitary towels and not tampons, and to avoid sexual intercourse or go swimming until the bleeding has stopped. This is to help prevent any infection. The bleeding is like a heavy period for the first day or so but this will lessen over time and you may even have a brown discharge before it stops completely. We also suggest that you avoid long soaks in the bath and shower instead, and ensure someone is around when you do this in case the hot water makes you feel faint/dizzy. Should you have concerns that your bleeding is not settling or you have a fever and 'flu-like' symptoms then contact your GP (General Practitioner) or contact us on the numbers below.
- **Next period:** Your next period may happen in four to six weeks after the procedure
- **Pain:** You may have period-like pains for a few days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this.
- **Check-ups and results**: Unless you are otherwise told, you will not be contacted specifically by the Early Pregnancy Unit (EPU) following your operation. However, if you have any concerns or questions you can telephone them directly.
- If this is not your first miscarriage and you meet certain criteria you may be referred to the recurrent miscarriage clinic. This may involve you having additional tests before this appointment. The staff on the Early Pregnancy Unit will discuss this with you.
- **Do I need to inform anyone about my miscarriage?** No. Staff on Daphne ward will have written to your GP and community midwife and any antenatal scans or appointments will have been cancelled, so you do not need to worry about doing this.
- **Future pregnancies**: It is possible to conceive a few weeks after your operation therefore you may wish to consider some form of contraception. We advise you to contact your GP or local family planning clinic for further advice. You are able to try for another pregnancy whenever you feel ready; there are no rules as to when you can do this. If you have any concerns about this then please speak to a member of staff.

Intended benefits of the procedure

- To remove any remaining tissue and blood clot in the uterus (womb) after a miscarriage. Many women find surgery a benefit as the miscarriage can be “over and done with” and they can plan around this. (Miscarriage Association 2010)
- In addition the doctor will suggest this procedure for the following clinical indications as opposed to the alternative methods for managing miscarriage:
    - to treat sepsis (infection)
    - to alleviate heavy bleeding
    - to ensure completion of miscarriage if suspicion of gestational trophoblastic disease (a rare and serious condition of early pregnancy)

Who will perform my procedure?

- This procedure will be performed or supervised by a Consultant Gynaecologist.

Alternative procedures that are available

Surgical evacuation of retained products of conception is not recommended if your pregnancy is less than seven weeks gestation due to the increased risks involved at this stage. We would therefore recommend you undertake one of the following two pathways listed below.

At any stage whether your pregnancy was less than seven weeks or greater than seven weeks you may also undertake one of the following pathways. Staff on the ward will explain these to you in more detail.

- If the bleeding is not excessive, and you prefer not to have an operation, you might wish to wait and allow the womb to expel the remaining tissue without assistance (**expectant management**).
- You might choose to have **medical treatment**, when you will be given some tablets to cause the womb to contract and empty itself. The success rate of a medical evacuation in emptying the uterus can, in some cases, be slightly less than the surgical approach although this is to be balanced against the risks of surgery.

Serious or frequently occurring risks

If you have a pre-existing medical condition, are obese, have significant pathology or have had previous surgery the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk).

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

- An ERPOC is a very safe operation, however, like all surgical procedures there are potential risks involved. Your Gynaecologist and nurse will ensure that the appropriate measures are taken to reduce the risk of complications. The main risks of the procedure are:

Serious risks

- Tear in the cervix. (Rare).
- Uterine perforation, this means a hole is made in the uterus. (Uncommon – up to 5 in 1000 women). This is a risk because the wall of the recently pregnant womb is very soft. This can cause trauma to other abdominal organs. If this happens it might be necessary to check that there is no internal bleeding using a laparoscopy. This is a procedure in which a laparoscope (telescope) is passed through a small cut below the navel. If there is internal bleeding, we might be able to control this using this 'key hole' surgery or you might need a larger 'open operation', which will take longer to recover from.
- Deep vein thrombosis (blood clot in the leg).
- Death (very rare – 0.5 in every 100 000).

Frequent risks

- Bleeding that lasts for up to two weeks is very common but blood transfusion is uncommon (1-2 in 1000 women)
- Infection of the lining of the womb. (Common – 3 in 100 women)
- Intrauterine adhesions (stickiness inside the womb) (Uncommon – 1 in every 200 women)
- There is a rare chance that we will miss some of the retained tissue and that you will require a further operation to remove it. (Common - up to 5 in 100 women)

What happens to any tissue or the fetus?

Any 'products of conception' (POC) i.e. tissue or the fetus removed during the operation are sent to the histopathology laboratory to confirm the miscarriage.

No other investigations are usually carried out into the cause of the miscarriage at this time unless specifically discussed with you.

Arrangements for disposal of the fetal remains:

There are standard procedures in place for the disposal of fetal remains which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.

- Fetal remains above 13 weeks gestation are cremated at the local crematorium in a monthly group service taken by the lead Chaplain for the Trust. In order to maintain patient confidentiality the patient's name is not used to identify the remains.

- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further Information, please contact Daphne Ward staff (01223 217636) or one of the Chaplaincy team (01223 217769),

What if I think I have miscarried before I come in for the operation?

This does sometimes happen, so it is advisable to have some sanitary towels and mild analgesia (pain relief) such as paracetamol or ibuprofen at home, just in case.

The bleeding may be very heavy, and you may pass blood clots, tissue or even a recognisable foetus.

If you are concerned that the bleeding is excessive (requiring you to change a sanitary pad every half an hour) please telephone us on the numbers listed later in this information leaflet.

We understand that bleeding heavily at home can be frightening - please do not hesitate to contact us if you are unsure what to do.

If you think you have miscarried, an operation may not be necessary, provided you are well and the bleeding has lessened. We would still like for you to attend so that staff can discuss this with you and together you can make an informed decision.

If clinically indicated it may be possible to arrange an ultrasound prior to the procedure. However, generally at this time it is **not** beneficial, as it would normally show blood in the womb anyway.

Please telephone Daphne ward to discuss the situation with nursing staff.

If you miscarry over the weekend, but are well, please telephone Daphne ward before 08:30 on Monday morning **or** attend the Day surgery unit as planned and discuss the situation with medical staff.

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 staff on:

- The Early Pregnancy Unit, Daphne Ward
  01223 217636
  Open 08:00 – 20:00 Monday to Friday and 08:30 – 14:00 at weekends
  Closed Bank holidays

- Inpatient Gynaecology ward
  01223 348544
  At all other times

Other useful sources of support:

- The Miscarriage Association
  01924 200799 (Monday-Friday 09:00 – 16:00)
  www.miscarriageassociation.org.uk

- The Royal College of Obstetricians and Gynaecologists
  Recovering Well Patient Information
  www.rcog.org.uk
  Information about recovering from surgical management of a miscarriage (pdf)

Your anaesthesia

There are three types of anaesthesia. The type chosen by your anaesthetist depends on the surgery you are undergoing as well as your health and fitness. Sometimes the different types of anaesthesia are used in combination.

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. Your anaesthetist achieves this by giving you a combination of drugs.

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. 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.

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. 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 Analgesia (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!

What are the risks of general anaesthesia?

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.

Day case anaesthesia

Many operations these days are carried out as day cases. This means you will come into hospital on the day of the operation, often only a short time before it is due to start. Sometimes you will be seen preoperatively for assessment, which is important because some people are not fit enough for day care. You will usually be seen by your anaesthetist on the admission day, in the day care ward.

Take all you normal drugs on the day of operation (unless they are diabetic drugs - do not take them): it is safe to take a sip of water to wash tablets down. The hospital will tell you when to stop eating and drinking before the operation: be sure to follow these instructions, or your operation may be cancelled

It is not usual to have a premed for day care operations, as these can slow recovery.

Most day case operations are more minor, and usually do not require major pain killers afterwards. However, you may need tablets, and it is important that you have some sort of pain killers at home. If you have not, the hospital should give you a supply to take with you.

Sometimes patients do have quite a bit of pain after day case operations, and may feel sick. Do not expect to feel normal straight away, and do not plan anything important for the evening after your day case operation. Occasionally the pain or sickness is severe enough for you to be kept in hospital, though that is unusual.

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	Gynaecology Division
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
Contact number	01223 217755
Publish/Review date	November 2011/November 2014
File name	Gynaeobs_erpoc.doc
Version number/Ref	4/CF230

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

Evacuation of retained products of conception **(ERPOC)**

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:

- The intended benefits of the procedure: As described in the attached leaflet
- Any serious or frequently occurring risks from the procedures including those specific to the patient: As described in the attached leaflet
- 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: Evacuation of retained products of conception (ERPOC) (for example: after a miscarriage)
.... Version/Date/Ref: 4, November 2011, CF230...............

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.

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): ....

Important notes: (tick if applicable)
❑ The patient has withdrawn consent (ask patient to sign/date here) ....
❑ See also advance directive/living will (e.g. Jehovah's Witness form)

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 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 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.)

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: ....