Patient agreement to investigation or treatment

Abdominal wall hernia surgery

Authors: Cambridge Upper Gastro-Intestinal Surgical Unit

Brief description:

- Your surgeon has recommended that you undergo surgery for an abdominal wall hernia. These hernias occur at different sites of the abdominal wall. Some types of these hernias have specific names such as umbilical, paraumbilical, epigastric, incisional or Spigelian. They have all in common that the hernia involves a weakness of the muscles and connective tissue of the abdominal wall.
- This leaflet has been designed to provide you with information about the nature of the surgery, what to expect in the recovery period and the potential risks. It is produced in a question and answer format. If you are unsure about anything contained in it, please ask one of the medical or nursing staff.
- 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.
- 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)

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....

About abdominal wall hernia surgery

An abdominal wall hernia is an abnormal protrusion through the abdominal wall. The protrusion contains a small bag of abdominal lining (the hernial sac) which can be empty or it can fill with abdominal contents such as bowel. Typically, hernias are more obvious when standing or straining (for example, coughing, heavy lifting, digging) as this forces bowel into the sac. Hernias usually develop over time for no obvious reason, although in some people there may be an inborn weakness in the abdominal wall. Occasionally, a strenuous activity will cause a lump to appear suddenly. They may occur at any age. These hernias occur at sites of weakness of the abdominal wall such as around the belly button or through the site of a previous surgical incision. However, they may occur at any site on the abdomen.

Hernias may simply present as a painless bulge that enlarges with standing or coughing. Commonly, though they cause an aching discomfort or a dragging sensation. Occasionally a piece of bowel or fat can get stuck and twisted within the hernia. This is very painful and can lead to a strangulated hernia which is a life-threatening emergency. It is generally recommended, therefore, that hernias be repaired to relieve symptoms or prevent such complications arising. Not all hernias have to be repaired. Your consultant will discuss the exact details of your hernia with you, although ultimately you will decide if you wish to have your hernia repaired.

Before your procedure

- Most patients attend a pre-admission clinic, when you will meet a member of the surgical team, usually a House Officer (junior doctor) or specialist nurse.
- 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 pharmacy. It helps us if you bring with you details of anything you are taking (for example bring the packaging with you).
- Hernia surgery can often be performed as a day case procedure under a brief general anaesthetic.

Prevention of Surgical Site Infection (SSI)

In order to prevent infection, hair from the area where you are being operated on may need to be removed.

Hair removal from the site of the operation up to sixty minutes before surgery reduces the risk of infection. This means that the hair removal procedure is usually carried out on the operating table. The skin is then cleaned with an appropriate skin preparation solution. This can leave a colouration to the skin which can be washed off.

You must not shave the area that is being operated on yourself; this will be carried out in the operating theatre. Shaving at home, or the night before surgery, increases the risk of infection as no matter how careful you are the skin may become irritated and this could increase the risk of infection.

It may be necessary during the procedure to shave other areas of your body if appropriate to allow equipment/machines, for example diathermy machines (used to seal blood vessels), to stick to your skin to achieve the best and safest performance.

Reference:

Department of Health. High Impact Intervention No 3: Preventing surgical site infection. Saving Lives: reducing infection, delivering clean and safe care: DH June 2005.

During your procedure

- At the start of your procedure, you will be given the necessary anaesthetic and/or sedation - see below for details of this.
- The first step is to make an incision over the hernia, dissect out the hernia sac and push its contents back into the abdominal cavity. The protruding sac can then be cut away. The hole in the abdominal wall can then be closed with sutures (stitches), and is often strengthened with the aid of an artificial mesh which is laid over the weakness and secured with sutures to prevent the hernia returning.
- Whether mesh is used is dependent on the size of the hernia and the strength of the surrounding tissues. Larger hernias require mesh or they are very likely to come back again. As a general rule, hernias larger than 2cm often require a mesh. It is the size of the weakness in the muscle wall that is important, not the size of the hernia that can be seen or felt. Therefore, often it is recommended that a decision to use mesh is made at the time of surgery.
- Mesh is made of a material (usually primarily prolene) which does not create a reaction from the body and is strong from the moment that you wake up. The material used in mesh is similar to that which is used in surgical sutures.
- The wound is then closed with invisible absorbable stitches under the skin. You will not be able to feel the mesh which is deep inside you. The dressing is shower-proof and we ask you to keep it on for five days after surgery.

After your procedure

- After your operation, you will wake up in the recovery room. You might have an oxygen mask on your face to help you breathe. You might also wake up feeling sleepy.
- You will have a small, plastic tube in one of the veins in your arm attached to a bag of fluid called a drip. This 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.

- **Pain Relief:** Local anaesthetic is usually injected into the wound to minimise pain immediately after surgery and this lasts for four to six hours. You will be given pain killers to take home and you should take these regularly for the first few days. As the discomfort decreases you will need less pain relief but you might not be fully comfortable for two to four weeks.
- **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 within about two hours.
- **When you can leave hospital:** This depends entirely on the size and complexity of the hernia. If you have a relatively small hernia you will be able to leave hospital the same or following day. If you have a large hernia you may need to stay in hospital for five to seven days. The actual time you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion.
- **When you can resume normal activities:**
- **Driving:** You are not insured to drive unless you are confident that you can brake in an emergency and turn to look backwards for reversing without fear of pain in the wound. This will usually be about 10 to 14 days after your operation. If in doubt you should check with your insurers.
- **Exercise:** It is safe to perform light duties immediately after the operation, but sensible to avoid heavy work for four to six weeks. However, the only thing to hold you back will be discomfort and, if the wound is not hurting, you can do what ever you like. If you have a larger hernia you are advised to refrain from vigorous physical activity for a longer period of time.
- **Returning to work:** You should be able to return to office work after two weeks and manual work after about four to six weeks.
- **Special measures you need to take after the procedure**:

  Wound: There are no stitches to remove. You should shower for the first five days and then you can soak in a bath and peel the plastic dressing off and leave the wound open to the air. If the wound becomes red, hot or mucky see you GP immediately in case you have a wound infection and need antibiotics. Alternatively you can ring the ward or Day Surgery Unit out of hours. Expect some numbness beneath the scar - this may be temporary or permanent. Bruising around the wound is sometimes seen - this looks dramatic but is harmless and will settle spontaneously.
- **Check up and results:** You will not normally be given a follow-up in the hospital clinic unless there are particular issues surrounding your operation (such as a larger hernia). It is occasionally necessary for you to visit outpatients if there are problems which cannot be dealt with by the Day Surgery staff over the phone or by your GP.

Intended benefits of the procedure

- To repair your hernia.
- To prevent future complications such as the requirement for emergency surgery if the hernia comes out and gets stuck.
- To relieve discomfort caused by the hernia.

- To reduce an unsightly bulge in the abdominal wall.
- To prevent the hernia from enlarging and causing further symptoms which will also make any future surgery more complex.

Who will perform my procedure?

- A suitably qualified and experienced surgeon, or a trainee surgeon under the direct supervision of a suitably qualified and experienced surgeon.

Alternative procedures that are available

- The principle alternative to the procedure outlined is not to have any surgery to the hernia. In some cases, particularly of very small or hernias through previous surgical incisions, the chances of life threatening problems such as strangulation are small. In most other cases no treatment runs the small risk that strangulation might occur and require an urgent operation. The hernia may also increase in size as time goes by.
- Hernias can be repaired using an incision on the abdominal wall, located close to or over the hernia itself. This information sheet deals with this type of hernia repair
- An alternative surgical technique for most hernia repairs is key hole surgery. Surgeons in the Upper GI surgical unit commonly perform this procedure as well. There are a number of factors that are taken into account when recommending the technique for repairing an abdominal wall hernia. Key hole surgery may allow you to recover faster after the surgery, however, not every hernia is suitable for key hole repair.
- Generally, small hernias are in the first instance better repaired using the simpler technique of making a single small incision rather than the several incisions required for key hole surgery.
- Each hernia is different and the different options considered for each patient. Neither technique is necessarily “better” than the other.
- There are no alternative procedures in the field of complementary medicine that can be used to treat an abdominal wall hernia.

Does my hernia really need to be repaired?

- Not all hernias need to be repaired. If a hernia is not causing symptoms or enlarging it may not need to be repaired.
- Hernias that are not causing symptoms are unlikely to develop serious complications such as strangulation.
- Ultrasound scans frequently diagnose hernias that cannot be seen or felt. We would usually be less likely to offer surgery if a hernia has not been seen or felt by you and cannot be identified when your surgeon examines you. This is because a hernia repair in this situation is unlikely to make you any better.
- If you have other serious medical problems or are frail, then the risks of repairing the hernia may outweigh the benefits
- Your surgeon will advise you whether he or she recommends surgery.
- You need to decide whether you wish to go ahead with surgery and is usually a decision best made in conjunction with your surgeon

Risks involved in the procedure

- Hernia repair is generally a very safe operation with few risks, but rarely complications can occur. Therefore, in the period following your operation you should seek medical advice if you notice any of the following problems:
    - Increasing pain, redness, swelling or discharge.
    - Severe bleeding.
    - Difficulty in passing urine.
    - High temperature over 38° or chills.
    - Nausea or vomiting.

Recognised complications include:

- **Damage to bowel -** Any surgery inside the abdominal cavity is associated with a very small risk of damaging other structures inside the abdomen. These include the bowels (or intestines). In a small hernia this risk is extremely low, virtually zero. However, in larger, more complex hernias, the risk is still low (5%). If the bowel is injured it would need to be repaired at the time of surgery. If this were to occur it may mean mesh could not be used in the hernia repair because of the risk of infection.
- **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 Infection –** The wounds can, rarely, become infected. If you notice redness, discharge or increasing pain from a wound you should consult with your doctor in case you need treatment.
- **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. This may simply disappear gradually or leak out through the wound.
- **Recurrence –** It is possible for a hernia to return after it has been repaired. Fortunately, recurrence after hernia surgery is uncommon with the use of mesh. Larger hernias are generally more at risk of recurring than smaller hernias. Sometimes another hernia can develop at a site close to where a hernia has been repaired, although through a separate part of the abdominal wall. Alternatively, a different type of hernia could develop elsewhere. Recurrence is also more likely if you are overweight
- **Deep vein thrombosis (DVT) and pulmonary embolus.** All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. Keyhole surgery has a lower risk of this, and we also are able to get patients up and about much quicker after these procedures than after conventional ‘open’ procedures. We do, however, give you some 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.

- **Mesh infection** – All artificial materials that are placed into the body carry a risk of becoming infected. This is very rare (estimated 1 in 100 chance). If this were to occur you would notice redness and pain around the hernia site, you may also have a fever and some smelly fluid escaping from the wound. Often this problem can be treated with powerful antibiotics, although a course of four to six weeks may be required. If the infection does not resolve then the mesh may have to be removed with an operation. This would mean that the hernia may eventually come back and several months or years later it may need to be repaired again.
- **Seroma** – An accumulation of fluid adjacent to mesh that is used to repair a hernia is called a seroma. This is actually part of the body's normal healing response. It may actually feel as if the hernia lump is still there! If the hernia is large it is expected that a seroma will develop. Fortunately, in itself, a seroma is not serious and most people do not notice it. If a seroma causes discomfort it may need to be drained under local anaesthetic in the X-ray department. This is where a small drain is placed into the fluid and the fluid is removed.
- **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 (almost always the sutures are 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 1 to 2cm 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.
- **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

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. Your anaesthetist achieves this by giving you a combination of drugs. Usually the first step is to inject medication intravenously (i.e. into a vein) through a small plastic tube, placed usually in your arm or hand. This is known as induction of anaesthesia. An example of a commonly used drug is Propofol. Induction is occasionally achieved by breathing gases. To maintain you in this state of unconsciousness, you will breathe a mixture of anaesthetic gases or vapours with oxygen. If the surgery or other factors require your muscles to be relaxed, for example in surgery on the abdomen, then a muscle relaxant drug is given and a tube is inserted into your throat and down your windpipe to help you to breathe. While you are unconscious and unaware your anaesthetist remains with you at all times, monitoring your condition and controlling your anaesthetic, replacing fluid or blood. At the end of the operation, your anaesthetist will reverse the anaesthetic and you will regain awareness and consciousness in the recovery room, or as you leave the operating theatre.

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.

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!

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.

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.

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

Privacy & Dignity

We are committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment. This means, with a few exceptions, we will care for you/your next of kin in same sex bays in wards with separate sanitary facilities for men and women.

In some areas, due to the nature of the equipment or specialist care involved, we may not be able to care for you/your next of kin in same sex bays. In these cases staff will always do their best to respect your/your next of kin's privacy and dignity, eg with the use of curtains or, where possible, moving you/your next of kin next to a patient of the same sex. If you/your next of kin have any concerns, please speak to the ward sister or charge nurse.

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

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Consent Form (Adults)

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

Abdominal wall hernia surgery

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 ....

  To repair your hernia.

....

- Any serious or frequently occurring risks from the procedures including those specific to the patient ....

  ...Wound haematoma; Infection; Recurrence; vascular or intestinal injury.

....

- 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: Abdominal wall hernia surgery ....

.... Version/Date/Ref: 1/June 2011/CF419..........................

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 (eg 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 agree to the use of photography for the purpose of diagnosis and treatment.	☐	☐
I agree to anonymised photographs being used for medical teaching.	☐	☐

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: ....