

**For staff use only:**

Hospital number:  
Surname:  
First names:  
Date of birth:  
NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_  
Use hospital identification label

**Consultant:**

## Consent Form

Patient agreement to investigation or treatment for neurosurgery,  
spinal surgery or vitreoretinal surgery

Please use 'Procedure completed'  
stamp below on completion:

**Interpreter's statement** (if appropriate)

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

**Signed** (Interpreter): ..... Date:       /       /            

**Name** (PRINT): .....

Or, please note the language line reference ID number: .....

**Consultant or other responsible health professional**

**Name and job title:** .....

Any special needs of the patient (e.g. help with communication)? .....

**A Name of proposed procedure or course of treatment**

(include brief explanation if medical term not clear)

**Patient's side** left / right or N/A

**B Statement of health professional (details of treatment, risks and benefits)**

**1** I confirm I am 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:

**a)** the intended benefits of the procedure (please state)

.....  
.....

**b)** the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

.....  
.....

**c)** what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:

.....  
.....

**d)** any extra procedures that might become necessary during the procedure such as:

Blood transfusion

Other procedure (please state)

.....  
.....

**e)** Was the patient born after 1 January 1997?

Yes

No

**2** The following information leaflet has been provided: .....

.....  
Version reference and date: .....

**or**  I have offered the patient information about the procedure but this has been declined.

**3** This procedure will involve:

General and/or regional anaesthesia

Local anaesthesia

Sedation

None

**Signed** (Health professional): ..... Date: DD/MM/YYYY

**Name** (PRINT): ..... Time (24hr): ..H.H. : ..M.M.

**Designation:** ..... Contact/bleep no: .....

## C Consent of patient/person with parental responsibility

I **confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

**Important:** please read the patient information on 'Consent' and then put a tick in the relevant boxes for the following questions:

### 1 Creutzfeldt Jakob disease (CJD)

a) Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.  Yes  No

b) Have you had a history of CJD or other prion disease in your family?  Yes  No

c) Have you ever received growth hormone or gonadotrophin treatment?  Yes  No  
*If yes, please give details below:*

Please specify:

(i) whether the hormone was derived from human pituitary glands  Yes  No

(ii) the year of treatment .....

(iii) whether the treatment was received in the UK or another country  UK  Other

d) Have you ever had surgery on your brain, eye or spinal cord?  Yes  No  
*If yes, please give details below:*

e) Since 1980, have you had any transfusions of blood or blood components (red cells, plasma, cryoprecipitate or platelets)?  Yes  No  
*If yes, please answer questions below:*

Have you either:

(i) received more than 50 units of blood or blood components,  Yes  No

**or**

(ii) received blood or blood components on more than 20 occasions  Yes  No

Where possible, please provide the names of all the hospitals where you received blood or blood components:

.....  
In the case of a positive reply to any CJD question, staff should immediately inform Infection Control on ext 3497 (bleep numbers 152-198 or 151-803) and the theatre co-ordinator (24 hour bleep number 152-585); out of hours contact the on call medical microbiologist via the hospital contact centre.

### 2 Photography, Audio or Visual Recording

a) I **agree** to the use of any of the above type of recordings for the purpose of diagnosis and treatment.  Yes  No

b) I **agree** to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.  Yes  No

### 3 Medical Training

I **agree** to the involvement of medical and other students as part of their formal training.  Yes  No

#### 4 Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.  Yes  No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.  Yes  No

I have listed below any procedures that I do not wish to be carried out without further discussion.

.....  
.....

I have read and understood the Patient Information entitled **Consent** and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ..... Date: ..... D D / M M / Y Y Y Y

Name of patient (PRINT): .....

*If signing for a child or young person; delete if not applicable.*

I confirm I am a person with **parental responsibility** for the patient named on this form.

Signed: ..... Date: ..... D D / M M / Y Y Y Y

Relationship to patient: .....

*If the patient is unable to sign but has indicated his/her consent, a witness should sign below.*

Signed (Witness): ..... Date: ..... D D / M M / Y Y Y Y

Name of witness (PRINT): .....

Address: .....

#### D Confirmation of consent

**Confirmation of consent** (where the treatment/procedure has been discussed in advance)  
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ..... Date: ..... D D / M M / Y Y Y Y

Name (PRINT): ..... Job title: .....

Please initial to confirm all sections have been completed: .....

#### E Withdrawal of patient consent

The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ..... Date: ..... D D / M M / Y Y Y Y

Signed (Health professional): ..... Date: ..... D D / M M / Y Y Y Y

Name (PRINT): ..... Job title: .....