Patient Agreement to Investigation or Treatment Consent Form | Abdominal Hysterectomy

NHS Greater Glasgow and Clyde

Patient Details (or pre-printed label)	
Hospital / Clinic / GP Practice:	
Patients Surname / family name:	
Patients first name:	
Date of Birth:	Gender: ☐ Male ☐ Female
CHI Number:	
Special requirements (eg: other language / communication label):	

Statement for practitioner
(to be filled in by practitioner with appropriate knowledge of proposed procedure)

Describe the proposed operation, investigation or other treatment:
Where appropriate specify site or side (write in full):

Tick all that apply:

- ☐ Total abdominal hysterectomy (removal of womb and cervix)
- ☐ Sub-total abdominal hysterectomy (removal of womb excluding cervix)
- ☐ Bilateral salpingo-oophorectomy (removal of both fallopian tubes and ovaries)
- ☐ Conservation of ovaries (fallopian tubes still routinely removed if possible)
- ☐ Omental biopsy (sample of fatty tissue overlying abdominal organs)
- ☐ Washings from the abdominal/pelvic cavity
- ☐ +/– Other:

Specific risks / complications

Serious risks:

- ☐ Damage to other organs such as bladder/ ureter (7/1000) or bowel (4/10,000)
- ☐ Haemorrhage requiring blood transfusion (23/1000)
- ☐ Return to operating theatre after initial procedure (7/1000)
- ☐ Pelvic abscess/infection (2/1000)
- ☐ Blood clot in major veins following surgery (4/1000)
- ☐ Unplanned subtotal hysterectomy (<1/100)
- ☐ Risk of death within 6 weeks (32/100,000)

Frequent risks:

- ☐ Wound infection, bruising, delayed healing or healing of scar with tissue thickening (keloid)
- ☐ Numbness, tingling or burning sensation around wound
- ☐ Urinary tract infection
- ☐ Ovarian failure

Additional procedures which may become necessary:

- ☐ Oophorectomy (removal of one or both ovaries for unsuspected disease)
- ☐ Repair of injury to bowel, urinary system or major blood vessels
- ☐ Blood transfusion
- ☐ Other:

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which my become necessary during the procedure (please specify major procedures above). I have explained who will be doing the procedure if not myself.

Signature of practitioner:

Name / Designation (Print):

Date:

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.

  Who will be performing my procedure on the day
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion**.

I agree

- to the administration of an anaesthetic or to sedation if required,
- to the procedure named on this form,
- to the emergency administration of blood or blood products.

Additionally you have to agree or disagree to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

Patient / parent agreement to treatment

Signature	Date
Name (print)	

Patient refusal for blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products, **even if this results in death**.

Signature	Date
Signature of practitioner	Date