Patient Information and consent to anterior resection

A patient's guide

Key messages for patients

- **Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation**.
- **Please read this information carefully,** you and your health professional will sign it to document your consent.
- **Please read this information carefully,** you and your health professional will sign a consent form on the day of the procedure to document your consent. An example of the consent form is at the back of this leaflet. After the procedure we will file the consent form in your medical notes
- **Please bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies)** and any information that you have been given relevant to your care in hospital, such as x rays or test results.
- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.
- Please call the colorectal clinical specialist nurse, Maria Walshe (mob: 07920 236 864 or 0207 288 5975) or the Enhanced Recovery Nurse on (Tel: 020 7272 3070 and ask to bleep 2713) if you have any questions or concerns about this procedure or your appointment.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

Cambridge University Hospitals NHS
NHS Foundation Trust

With thanks to Cambridge University Hospitals for the use of their content

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

About anterior resection

You have been recommended to have an ‘anterior resection’ as the surgical treatment for your disease which involves removing some or all of the rectum and adjacent sigmoid colon. This operation is for cancers of the rectum and some cancers of the sigmoid colon. The same operation is also performed for some non-cancerous bowel conditions. It will be performed under general anaesthetic.

The rectum is the lowest 15cms of the bowel. It is the place where the stool is normally stored prior to going to the lavatory so that its removal does alter bowel function afterwards. You would tend to have a more frequent, urgent and looser stool after surgery.

When an anterior resection is performed it is usually possible to join the two ends of the remaining bowel together afterwards. However, the more rectum that is removed, the greater is the possibility that you would need a temporary bag (stoma) to protect the join of the bowel. An ileostomy is the commonest temporary stoma used. This will be in place for a number of months and is reversed after an X-ray examination to check that the bowel join is healthy. If you need chemotherapy after your surgery the stoma will not be closed until after that has finished. There is also a chance of a permanent bag (a colostomy). If there is a likelihood of a stoma you will be counselled by your surgeon and stoma nurses before surgery.
You may have been advised to have radiotherapy or chemo-radiotherapy prior to your operation.

Intended benefits

The aim of the surgery is to remove the cancer – completely if possible. For most patients this will provide a cure or significant improvement of their bowel problems. For cancer operations, surgery gives the best chance of cure, and the treatment may need to be combined with chemotherapy and/or radiotherapy. Even in cancer surgery, where certainty of cure is difficult to guarantee, the benefits should be long lasting.

Who will perform my procedure?

Your surgery will be performed by a surgeon with particular skills and training in bowel surgery. This is usually a consultant surgeon or senior specialist registrar, often under consultant supervision.

Before your admission

You will need to attend the pre-operative assessment clinic, which is run by nurses. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy.
Please bring all your medications and any packaging (if available) with you. You may have a blood test and ECG performed, and also swabs for MRSA.

We will tell you about the bowel preparation needed prior to surgery and if necessary we will give you some laxative to take on the day before surgery.

Your operation will require a general anaesthetic. We explain about the different types of anaesthesia and post-operative pain relief at the end of this leaflet. You will see an anaesthetist before your procedure to discuss the best options for you.

Most people who have this type of procedure will need to stay in hospital for three to six days after the operation. Those patients with medical problems or special needs may need to stay in hospital longer.

Day of surgery admission

Most patients are admitted on the day of surgery. If you need to have a completely empty bowel you should take the ‘bowel prep’ (given to you at the pre-admission clinic) at home the previous day. Some patients simply need an enema on the ward when admitted to clear the lower bowel prior to surgery.

Hair removal before an operation

If you need hair removal from the surgical site this will be done using an electric hair clipper with a single-use disposable head, after you have been anaesthetised. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

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.

During the procedure

Before your procedure, we will give you the necessary anaesthetic - see below for more details. Your anaesthetist will also discuss post-operative pain relief with you and if you are having an epidural this may be put in before you are anaesthetised. You will need to have a catheter inserted into your bladder once you are asleep so we can measure urine output. This will be removed within the first few days after the operation.

Surgery for rectal and sigmoid cancer can be performed by an 'open' operation with an incision in the abdomen or by laparoscopic 'keyhole' surgery. Keyhole surgery still requires an incision through which the tumour is removed. The choice of method depends on a number of factors including the size and position of the cancer, your build and coexisting medical conditions, any previous operations on your abdomen, and surgeon preference. Please feel free to discuss this with your surgeon if you need clarification.
With keyhole surgery it is sometimes not possible to complete the procedure using this technique; there would be a need to convert to an open operation in this case. At the start of the operation we take the opportunity to look inside your tummy at the rectum and other parts of the abdomen – for example the liver, stomach, small intestine or ovaries.

The rectum and colon above it are then mobilised (freed up from their surrounding attachments) so that the rectum can be safely removed, along with some of the mesorectum (fatty tissue that carries the blood vessels and lymph drainage to the bowel). Often the adjacent part of the colon is removed as well to enable better clearance of the disease. In most cases the remaining bowel ends can be joined up again either using special stapling instruments or sutures (stitches). If a stoma (where the bowel is brought out to the skin) is needed then this will have been discussed in advance. At the end of the operation the abdominal wall is stitched together and then the skin is closed, usually with absorbable sutures (so there is no need for stitches to be removed after the procedure).

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward. You will also have a tube (catheter) in your bladder to drain away urine – this enables careful measurement and avoids the need for you to get out of bed to urinate.

After certain major operations you may be transferred to the intensive care unit (ITU) or high dependency unit in ITU.

These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

Enhanced recovery

Where possible we make use of 'enhanced recovery' principles to minimise the impact of surgery on the body and enable a rapid return to normal activity. There are many aspects to this process which includes preoperative, intraoperative and postoperative procedures.

We aim to minimise pain; perform careful surgery; avoid unnecessary drips, tubes and drains; enable you to eat and drink straight after your operation; encourage early mobilisation to stimulate recovery and allow you to go home soon and safely. We want you to be involved with this and need your help to improve your recovery.

Eating and drinking. You will be given special drinks, and advised when to drink them, to ensure you get nutrition right up until a few hours before your surgery. It is safe to drink and even eat straight after surgery provided that you feel a desire to do so. You should not eat or drink if it makes you feel sick or bloated.

Getting about after the procedure. We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. You will have daily injections which reduce the chance of blood clotting in your legs (DVT). Typically, you will be helped into a chair the following day. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital. Most people who have this type of procedure will need to stay in hospital for about a week. Sometimes complications arise and these will delay discharge. When you go home we would expect you to be mobile, comfortable and able to eat safely. 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.

Resuming normal activities including work. Most people who have had this procedure can get back to normal activities within six to eight weeks. Initially you will feel more tired than usual but this should not stop you from doing anything, because activity is beneficial. For driving you need to feel safe and to be able to brake in an emergency – this often takes two to four weeks. When going back to work see if you can start half days or work a bit from home until your energy levels are improved.

Special measures after the procedure: 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 control. This is usually with either a spinal injection, patient-controlled analgesia or pain relieving injections into the abdomen, followed by a combination of pain relieving tablets.(see below for details).

Check-ups and results: Before you leave hospital, we will give you details of when you need to return to see us, for example outpatient clinics or for the results of your surgery. At this time, we can check your progress and discuss with you any further treatment we recommend.

Significant, unavoidable or frequently occurring risks of this procedure

Surgery to remove part of the bowel is a major operation and there are certain risks known to be associated with it. These include the risks of surgery in general, the risks particularly associated with bowel surgery and the risks of anaesthetic described in more detail over the page. The general risks of surgery include problems with the wound (for example, infection), breathing (for example, chest infection), heart (for example, abnormal rhythm or occasionally a heart attack), blood clots (for example, in the legs or occasionally in the lung) or kidney function (for example, kidney failure). Those specifically related to anterior resection include problems with the seal where the bowel has been joined (‘anastomotic leak’), a transient blockage of the bowel, bleeding or infection in the abdominal cavity. Rarely, further surgery is required to put right such complications. If there is a leak from the bowel join (anastomotic leak) then surgery is often required and this usually requires a stoma to be created; this is a serious complication but the risk is low, of the order of 5-7%.

Sometimes during the operation it becomes apparent that the disease is more complicated than was anticipated: the type of surgery may need to be altered to achieve the desired result. This may mean removing more bowel or part of a nearby organ (for example, small intestine, bladder or ovary). The consent form you sign will include this possibility. If there is any part of you which you specifically do **not** wish to be removed then this must be written clearly on the consent form before signing. As explained earlier there may be a need for a stoma and this is usually predictable in advance. Rarely however, we may decide during the operation that a stoma is required and there is a remote risk this could be permanent.

In men there is a risk of impotence (failure to achieve an erection) in this kind of surgery. There is also a chance of retrograde ejaculation (semen going into the bladder instead of out of the penis during ejaculation). Obviously every effort is made to minimise this risk but you need to be aware of it. These risks are greater when radiotherapy and surgery are combined.
In women, there is a risk of discomfort or dryness during sexual intercourse, and some women no longer experience sexual orgasm. Again, this risk is greater when radiotherapy and surgery are combined.

Most people will not experience any serious complications from their surgery. The risks increase for the elderly or overweight and for those who already have heart, chest or other medical conditions such as diabetes or kidney failure. There is a very small risk of death. You will be cared for by a skilled team of doctors, nurses and other health care workers who are involved in this type of surgery on a daily basis. Any problems that arise can be rapidly assessed and appropriate action taken.

Alternative procedures that are available

For most of the conditions where anterior resection is advised, the only alternative to surgery is medical treatment with drugs. Where there is a cancer of the bowel, drug treatment alone will not cure the disease. Occasionally it is possible to remove a rectal cancer from within the back passage without the need for major surgery; this form of surgery is only suitable for a small minority of patients. This option (trans-anal resection) will be discussed if appropriate.

If you were to decide against surgery then your cancer would progress, though usually quite slowly over months. This could result in bleeding, the development of a blockage in the bowel and eventually spread of cancer to other parts of the body.

Anaesthesia

Anaesthesia means 'loss of sensation'. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness**. In an anterior resection operation, often different types of anaesthesia are used together.

Day of operation

Before your operation (unless you've been invited in earlier to meet the consultant anaesthetist) you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

The anaesthetist may then give you pain relievers, to ensure you have a level of these drugs in your system prior to the operation, and may give other medication, depending on your health and fitness.

Moving to the operating room or theatre
You will change into a gown before your operation (and dressing gown to keep warm), and then we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting**.

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) will be inserted. If a spinal or epidural anaesthetic is going to be performed, it will be performed at this stage, before the general anaesthetic is administered.

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 into the intravenous line or drip. Just before you have the general anaesthetic you will be asked to breathe oxygen in through a face mask, to fill your lungs up with oxygen.

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 at the correct level of unconsciousness for the period of the surgery. 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.

Regional anaesthesia

Regional anaesthesia includes epidurals, spinals, o and local anaesthetic blocks of the nerves to the abdomen. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. In an anterior resection, Regional anaesthesia will usually be performed in addition to a general anaesthetic. Regional anaesthesia will also provide pain relief after your surgery for hours or sometimes days. Your anaesthetist will discuss the procedure, benefits and risks with you. **Spinal anaesthetic (the most common type of regional anaesthesia used in this operation)**
In anterior resections, a spinal anaesthetic is often used as well as general anaesthetic.

What is a spinal?
A local anaesthetic is injected through a very fine needle into the small of your back. This will numb the nerves to your abdomen and legs.

Advantages of spinal anaesthesia
There may be:

- less strain on the heart and lungs
- reduced sickness and vomiting
- excellent pain relief immediately after surgery
- less risk of injury when you are put into the position for your surgery

After your spinal

As sensation returns you may experience some tingling in the skin as the spinal wears off. If you become aware of some pain from the operation site then you should take some pain relief. You should tell the ward staff about any concerns or worries that you have.

Side effects and complications

As with all anaesthetic techniques there is a possibility of unwanted side effects or complications.

Uncommon side effects include:

- Headache – when the spinal wears off and you begin to move around there is a risk of developing a headache.
- Difficulty passing water (urinary retention) – you may find it difficult to empty your bladder normally as long as the spinal lasts. Your bladder will usually work normally when the spinal has worn off, although sometimes a urinary catheter (tube into the bladder) will need to be inserted.
- Pain during injection – occasionally you may feel pain or 'pins and needles' in your legs or bottom during the injection. You should tell your anaesthetist immediately as this may indicate irritation or injury to a nerve and the needle will have to be repositioned.

Rare complications

Nerve damage – This is a rare complication of spinal anaesthesia. There may be temporary loss of sensation, pins and needles and sometimes muscle weakness that may last for a few days or even weeks but almost all make a full recovery in time. Permanent nerve damage is even more rare and has about the same chance of occurring as major complications of general anaesthesia.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after regional anaesthesia. When the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of 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 performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)

- Feeling sick and vomiting after surgery
- Sore throat

- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- 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
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications

- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists' website: www.rcoa.ac.uk

Pain relief

Pain relief (analgesia) after major bowel surgery may be provided by regional analgesia, either by an epidural, caudal or a spinal injection (depending upon your particular operation), or by strong pain killers such as morphine, usually administered into the vein by a patient controlled analgesia system. The latter is a system whereby you control the administration of pain killer into your intravenous drip by pressing a button. Local anaesthetic injections around nerves which supply the abdominal wall may also be used, for example TAP blocks.

Your anaesthetist will discuss pain relief with you prior to surgery, along with the risks and benefits of the techniques.

The risks of the epidural and spinal pain relief are similar to the risks of regional anaesthesia, as listed above.

Other analgesics may also be administered as injections, tablets or suppositories (if appropriate), particularly after a day or two, when the pain will be decreasing and the epidural or patient

controlled analgesia are stopped.

This hospital has an ‘Acute pain team’, who are a team of nurses and anaesthetists who specialise in pain relief after surgery. One of the team may visit you after your surgery to help and advise the ward team with the management of any pain you may have.

Information about important questions on the consent form

1 Photography, Audio or Visual Recordings

As a teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

2 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

Information and support

We might give you 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 the doctor or ward staff.

If you have further questions please contact

- The Enhanced Recovery Nurse by calling switchboard on 200 7272 3070 and ask to bleep 2713, or;
- The colorectal clinical specialist nurse, Maria Walshe (mob: 07920 236 864 or 0207 288 5975) if you have any questions or concerns about this procedure or your appointment.

Privacy & Dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.
For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0300 123 1044

Patient advice and liaison service (PALS)

If you have a question, compliment, comment or concern please contact our PALS team on 020 7288 5551 or
whh-tr.whitthealthPALS@nhs.net

If you need a large print, audio or translated copy of this leaflet please contact us on 020 7288 3182. We will try our best to meet your needs.

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Patient agreement to investigation or treatment where patient has capacity to consent

Patient's surname..... Patient's first names .....
Date of birth ..... NHS / hospital number ..... .
Male Female Special requirement (language/communication method)
.....
Responsible health professional .....
Job title .....

Proposed procedure or course of treatment (include brief explanation if medical term not clear). .....
Laparoscopic anterior resection +/- open +/- defunctioning ileostomy
.....
.....

Statement of health professional (who has appropriate knowledge of proposed procedure as specified in the consent policy)
I have explained the procedure to the patient. In particular I have explained:
The intended benefits ...To treat growth or inflammation in the colon or rectum.....
.....
serious or frequently occurring' risks Chronic pain, bleeding, infection, collection, injury to other organs including bowel and ureter, anastamotic leak, chest infection, atelectasis (lung collapse), blood clots (DVT/PE), heart attack, stroke, death, hernias in incisions, scarring, poor wound healing, surgical site infectionchange in bowel habit (constipation/ diarrhoea), incontinence, high output stoma, acute kidney injury, erectile dysfunction (impotence), retrograde ejaculation, sexual dysfunction, reduced fertility

The procedure will involve:
☒ general anaesthesia ☒ regional anaesthesia ☒ local anaesthesia ☐ sedation

Any extra procedures that may become necessary during the procedure
☒ Blood transfusion .....
☒ Other .....Ureteric stenting, removal of other organs - bladder, ovary, fallopian tube.....

☒ **A leaflet/tape** has been provided (name & code) .....S&C/GralSurg/PI&CAntRes/01.....
☒ **Consenting to treatment leaflet** has been provided .....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of the patient.

Signed ..... **Date** .....
Name (PRINT) ..... **Job title** .....
Contact details .....

Statement of interpreter, (where appropriate). I have interpreted the information above to the patient to the best of my ability and in a way, which I believe she/he can understand.

Signed ..... **Date** .....
Name (PRINT) .....

Top copy accepted by patient: Yes/No (Please ring)

Statement of patient

Identifier label

Please read this form carefully and make sure that you understand the benefits and risks of the proposed treatment. If you have any further questions please ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

As this is a teaching hospital, medical and nursing students may accompany the consultant during your treatment for training purposes. If you have any objection to this, please tell your doctor/nurse. This decision will not affect your treatment or care.

I agree to the procedure or course of treatment that is described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have the appropriate experience.

I understand that I will have the opportunity to discuss the details of general or regional anaesthesia with an anaesthetist before that procedure, unless the urgency of the procedure prevents this.

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 understand that human tissue (such as skin, muscle, organs) removed during the procedure may be sent to the laboratory for tests. Only with my express consent may any of the remains of these tissues be used for research or education. **(see signature below)**

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 to be carried out** without further discussion.

.....

.....

.....

Patient's signature ..... **Date** .....

Name (PRINT) .....

Signed consent for research on removed tissue .....

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signed ..... **Date** .....

Confirmation of consent (to be completed by a health professional when a patient is admitted for a 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 she/he has no further questions and wishes the procedure to go ahead.

Signed ..... **Date** .....

Name (PRINT) ..... **Job title** .....

Important notes: (tick if applicable)

- ☐ See also advance directive/living will (e.g. Jehovah's Witness form)
- ☐ Patient has withdrawn consent (ask patient to sign/date here)

Guidance to health professionals

(to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoir to health professionals and patients, by providing a checklist of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent?

Everyone aged 16 or more is presumed to be competent to give consent for him or herself, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to counter sign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for him or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

they are unable to comprehend and retain information material to the decision and/or

they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for him or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks, which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition, if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on the reverse of this page of the form or in the patient' s notes.