CONSENT FORM 1 (ADULT)

Abdominal Wall Reconstruction (AWR)

Patient agreement to investigation or treatment

Patient details (or attach pre-printed label)

Patient's surname: _____

Patient's first names: _____

Date of birth: _____

NHS or Hospital number: _____ **Male** ☐ **Female** ☐

Consultant or other health professional responsible for your care:

Name: _____ **Job title:** _____

☐ **Any special requirements of the patient?**

(Please specify, e.g. help with communication)? _____

_____

_____

_____

Attach pre-printed label or complete

Patient's surname: _____

Patient's first name: _____

Date of birth: _____

NHS or Hospital number: _____

A. Name of proposed procedure or course of treatment

Abdominal Wall reconstruction ----------

B. Statement of Health Professional

1. **I confirm I am a health professional with appropriate knowledge of the proposed procedure. I have explained the procedure to the patient. In particular, I have explained:**

a) **<u>The intended benefits of the procedure</u>: Improving the structure and the stability of the abdominal wall by application of absorbable/permanent mesh behind the six-pack muscles or other muscles of the abdomen. If the defect is too big to be directly closed, a mesh is applied to "bridge" the hernia defect. This will also include excision of skin and umbilicus through vertical and/or transverse skin approach with or without drains application, and possible recreation of new umbilicus if applicable. A urinary catheter may be needed during and after the procedure.**

b) **<u>Significant unavoidable or frequently occurring risks</u>:**

☐ **Infection** ☐ **Bleeding** ☐ **Scar (Hypertrophic/keloid scar)** ☐ **Wound breakdown** ☐ **Delayed healing** ☐ **Pain or Numbness** ☐ **Asymmetry or Residual bulge** ☐ **Loss /flattening of reconstructed umbilicus (if applicable)** ☐ **Skin excess on the ends of the scars (standing cones)**	***<u>Less common</u>*** ☐ **Seroma (Fluid collection)** ☐ **Hematoma (Blood collection)** ☐ **Chest infection** ☐ **Reoperation** ☐ **Further surgery** ☐ **Prolonged hospital stay** ☐ **Long rehabilitation** ***<u>Rare</u>*** ☐ **Bowel injury** ☐ **Vessel injury** ☐ **Blood clots (Deep venous thrombosis/Pulmonary embolism)** ☐ **Increase pressure inside the abdomen** ☐ **Life-threatening potential**

c) **<u>Any available alternative treatments (including no treatment) and any particular concerns of this patient</u>: Conservative treatment – abdominal binder (temporary) – other:** _____

_____

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

☐ Blood transfusion ☐ Other procedure (please state) _____

2. **The following information leaflet has been given:** _____

3. **This procedure will be done under *<u>General Anaesthesia</u>*, supplemented by injection of local anaesthesia to decrease post operative pain.**

4. **Signed by health professional:** _____ **Date:** ____/____/____

Name (Print): _____ **Designation:** _____

Please tick to state you have given the white carbon copy to patient ☐

Attach pre-printed label or complete

Patient's surname: _____

Patient's first name: _____

Date of birth: _____

NHS or Hospital number: _____

C. Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do 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.

I agree to the procedure or course of treatment 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 appropriate experience.

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 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 which I do not wish to be carried out without further discussion:

_____

_____

Patients signature: _____ Date: ____/____/_____

Name (Print): _____

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Witness signature _____ Date: ____/____/_____

Name (Print): _____ Address: _____

D. Confirmation of Consent

Confirmation of consent is to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance.

I confirm I am a health professional with an appropriate knowledge of the proposed procedure. On behalf of the team treating this patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Health professional signature _____ Date: ____/____/_____

Name (Print) _____

Attach pre-printed label or complete

Patient's surname: _____

Patient's first name: _____

Date of birth: _____

NHS or Hospital number: _____

E. Advanced directive

☐ The patient has advanced directive

F. Interpreters statement (where appropriate)

I have interpreted the information to the patient to the best of my ability and in a way in which I believe s/he can understand.

Interpreter signature: _____ Date: ____/____/____

Name (Print) _____

G. Withdrawal of patient consent

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

Patients signature: _____ Date: ____/____/____

Health professional signature: _____ Date: ____/____/____

Name (print) _____ Job title _____