Barts Health NHS
NHS Trust

Consent Form 2

Parental Agreement to Investigation or Treatment for a Child or Young Person

Patient details (or pre-printed label)

Patient's Surname/ Family name [redacted]

Patient's First name

Date of Birth

NHS number *(or other identifier)* [redacted]

Sex ☐ Male ☑ Female

Responsible health professional FIRTH G.

Job title CONSULTANT

Special requirements of patient *(e.g. language/communication)*

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

LEFT FOOT CHARCOT INJURY FOR EXT + ORIF + CPPP + CAST

Statement of health professional (To be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy. It is expected that for all planned procedures consent is obtained prior to the day of treatment).

I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits IMPROVE ROM/MOVEMENT HELP BLOOD HEALING IMPROVE SYMPTOMS, MAINTAIN NORMAL ANATOMY OF JOINT.

Serious or frequently occurring risks SCAR INFECTION NERVE/VESSEL INJURY, NEED FOR ADDITIONAL PROCEDURE, ANAESTHETIC RISKS

Any extra procedures which may become necessary during the procedure

☐ blood transfusion

☐ other procedure (please specify)

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 this patient and his or her parents.

☐ The following leaflet/tape has been provided

This procedure will involve:

☑ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed [signature] Date 17/09/18

Name (PRINT) NATALIA T Job title CONSULTANT

Who to Contact (if further information is required or to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed Date

Name (PRINT)

YELLOW COPY: HEALTH RECORDS BLUE COPY: PATIENT WHITE COPY: PATHOLOGY

Statement of parent

Patient identifier/label

Please read this form carefully. 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 and **I confirm** that I have 'parental responsibility' for this child.

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 my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the 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 the life of my child or to prevent serious harm to his or her health.

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

I have been given a copy of my / my child's consent form.

Parent's signature [signature] Date 17/09/18

Name (PRINT) [redacted]

Potential for research on specimens taken for diagnostic purpose

I have received information on the collection and use of surplus tissue for research and have had the opportunity to ask questions.

I agree that tissue (including blood) left over from my child's procedure, following examination and any tissue-derived product, such as DNA, may be stored and used for approved research, including genetic research within a hospital, university, non-profit institution or a company laboratory in the EU or overseas.

I agree that my child's health records may be used by authorised members of staff who are not directly involved in my child's clinical care, for research approved by a research ethics committee and in compliance with the Data Protection Act (1998).

Patient/parent preference for tissue use, exclusions

I have read (or have had read to me), understood and agree to the statements above

Parent's signature Date

If the parent declines research do not take signature and tick ☐ **NO TO RESEARCH**

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

Witness Signature Date

Name (PRINT)

Child's agreement to treatment (if child wishes to sign)

I agree to have the treatment I have been told about.

Name Date

Signature

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child have signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish 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)

☐ Parent has withdrawn consent (ask parent to sign/date here)

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