

PLEASE TICK ALL APPROPRIATE BOXES

The Leeds Teaching Hospitals

NHS Trust

Consent Form 1

TO BE RETAINED IN
PATIENT'S NOTES

Pat

NHS: 458 414 0707
PAS: 2405293
DOB: [REDACTED]
SEX: FEMALE

ion or Treatment

Patient's surname

Date of birth

Job title

☐ Male

Female ☒

NHS number (or other identifier) 97856

Special requirements
(eg other language/other communication method)

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) RIGHT HUMERUS FREE FIBULA OPLN
REDUCTION AND INTERNAL FIXATION NON-UNION OF BONE GRAFT
BMP-7 + MARROW CELLS

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have read and understood the guidance to health professionals overleaf.

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits STABILISATION RIGHT ARM

Significant, unavoidable or frequently occurring risks INFECTION, BLEEDING, SLIGHTLY FREE FIBULA LOSS, PAIN, NON-UNION, FLEXION CONTRACTURE OF DORSAL SITE, COMMON PERONEAL NERVE DAMAGE, PLE, DVT

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.

☐ The following leaflet/tape has been provided: About the Consent Form

To be filled in by Health Professional

This procedure will involve:

☒ general and/or regional anaesthesia

☐ local anaesthesia

☐ sedation

Signed (Health Professional)

Name (PRINT)

Job title

Date

To be filled in by Anaesthetist if general or regional

☐ I have discussed the anaesthetic including the benefits and risks and noted these on the Anaesthetic Record

Signed (Anaesthetist)

Name (PRINT)

Date

Contact details (if patient wishes to discuss options later)

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

Signed

Date

Name (PRINT)

Pink copy accepted by patient: Yes ☐ No ☐

YELLOW COPY: CASE NOTES

WHITE COPY: PATHOLOGY

PINK COPY: PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy 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 understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

1

I agree it may be stored: Yes ☐ No ☐ and then used for:

- Further diagnosis and treatment which might benefit myself or my family in the future Yes ☒ No ☐
 - Teaching, research, study and audit for the benefit and future interests of all patients Yes ☒ No ☐
- (Any research using your stored tissue or medical records will be confidential and require approval by a Research Ethics Committee)*

I understand that photographs or video recordings may be made as a part of my assessment or treatment. If this is going to happen I will be told either beforehand or in exceptional circumstances afterwards. These may be used without my consent within the clinical setting for education or research in a way that I cannot be recognised. Separate information will be provided and my written consent obtained when such material would not form a direct part of my care and when it might be published or used for education or research or where I might be recognised. *Health professionals read notes overleaf.*

Health professionals read notes overleaf.

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.

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 overleaf).

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

Important notes: (tick if applicable)

- ☐ See also advance directive/living will (eg Jehovah's Witness form)

(ask patient to sign/date here) Signed..... Date