Before completing consent please read "Guidance For Health Professionals" for consent form 2 provided

Click here to read Guidelines (under the section called New Department of Health "Guidelines to Consent'

ORCHIDOPEXY

Covid 19 Version

CONSENT FORM
for
UROLOGICAL SURGERY

(Designed in compliance with DH Department of Health consent form 2)

PARENTAL AGREEMENT TO INVESTIGATION OR TREATMENT FOR A CHILD OR YOUNG PERSON

Patient Details or pre-printed label

Patient's NHS Number or Hospital number	
Patient's surname/family name	
Patient's first names	
Date of birth	
Age	
Sex	
Responsible health professional	
Job Title	
Special requirements *e.g. other language/other communication method*	

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
ORCHIDOPEXY **SIDE .** THIS INVOLVES AN INCISION IN THE GROIN AND THE SCROTUM TO BRING THE TESTIS DOWN INTO THE CORRECT POSITION	- GENERAL/REGIONAL - LOCAL - SEDATION

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy) I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits TO BRING TESTIS DOWN INTO SCROTUM

Serious or frequently occurring risks including any extra procedures, which may become necessary during the procedure. 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 Please tick the box once explained to child/parents

OCCASIONAL
- ❑ RARELY, INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT
- ❑ OCCASIONALLY THE TESTIS WILL REMAIN HIGH IN THE SCROTUM AFTERWARDS
- ❑ OCCASIONALLY NOT POSSIBLE TO BRING DOWN

RARE
- ❑ BLEEDING REQUIRING FURTHER TREATMENT
- ❑ RARELY, THE TESTIS CAN SHRINK DUE TO POOR BLOOD SUPPLY AFTER THIS CONDITION

VERY RARE
- ❑ WE CAN NOT GUARANTEE FUTURE FERTILITY
- ❑ VERY RARELY THE PROCEDURE NEEDS TO BE REPEATED

ALTERNATIVE THERAPY: OBSERVATION

Covid 19
- it is not possible to give an accurate estimate of contracting Covid 19 while in hospital
- Elective patients who develop hospital-acquired Covid-19 have a postoperative 30 day mortality of 16.2%, with the two-thirds who experience pulmonary complications having a mortality rate of 23.8%

(Source - https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/tool-5/#3)

A blood transfusion may be necessary during procedure and parent agrees **YES or NO (Ring)**

Signature of Health Professional	Job Title
Printed Name	Date

The following leaflet/tape has been provided

Contact details (if child/parents wish to discuss options later) _____

Statement of interpreter 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.

Signature of interpreter:	Print name:	Date:

Copy (i.e. page 3) accepted by patient/parents: yes/no (please ring)

Patient identifier/label

Parent/child copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
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Signature of Health Professional	Job Title
Printed Name	Date

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Contact details (if child/parents wish to discuss options later) _____

Statement of interpreter 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.

Signature of interpreter:	Print name:	Date:

Patient identifier/label

Statement of parent

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 3, 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 and your child. 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.
- 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 children 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/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.

_____

_____

Signature of Parent:		Print please:	Date:

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

Signature of child:		Print please:	Date:

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.

Signature of Health Professional	Job Title
Printed Name	Date

Important notes: (tick if applicable)

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

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