



## INFORMED CONSENT FOR PROCEDURE/OPERATION

FULL NAME OF PATIENT: \_\_\_\_\_

I.D. NUMBER: \_\_\_\_\_

PERSON OBTAINING CONSENT: \_\_\_\_\_

I have explained the nature, risks and possible consequences of the surgical procedure to the undersigned patient or person legally competent to give consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **PROPOSED PROCEDURE: EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY (ESWL)** **SIDE .....**

THIS INVOLVES THE ADMINISTRATION OF SHOCKWAVES THROUGH THE SKIN TO FRAGMENT URINARY TRACT STONES INTO SMALL ENOUGH FRAGMENTS TO PASS NATURALLY

**INTENDED BENEFITS:** To treat urinary tract stones

**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.

#### **COMMON**

Bleeding on passing urine for short period after procedure.  
Pain in the kidney as small fragments of stone pass after fragmentation.  
Urinary tract infection from bacteria released from the stone when fragmented, needing antibiotic treatment.

#### **OCCASIONAL**

Stone will not break as too hard, requiring an alternative treatment.  
Repeated ESWL treatments may be required.  
Recurrence of stones.

**RARE**

Kidney damage (bruising) or infection needing further treatment.  
Stone fragments occasionally get stuck in the tube between the kidney and the bladder requiring hospital admission and sometimes surgery to remove the stone fragment.  
Severe infection requiring intravenous antibiotics and sometimes drainage of the kidney by a small drain placed through the back into the kidney.

**ALTERNATIVE THERAPY**

Telescopic surgery, open surgery or observation to allow spontaneous passage.

**NAME OF HEALTH PROFESSIONAL:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**STATEMENT OF PATIENT:**

Please read this form carefully, particularly the previous page, which describes the benefits and risks of the proposed treatment.

I agree:

- To the procedure or course of treatment described on this form ☐
- To a blood transfusion if necessary ☐

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.
- 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 prevent serious harm to my health.

I have been told:

- About additional procedures which may become necessary during my treatment.

**NAME OF PATIENT:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_