



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: RADICAL RETROPUBIC PROSTATECTOMY AND PELVIC LYMPH NODE DISSECTION

REMOVAL OF THE WHOLE PROSTATE GLAND, SEMINAL VESICALS AND DRAINING NODES FOR CANCER, AS WELL AS TYING OF THE VAS DEFERENS. INCISION IN LOWER HALF OF ABDOMEN

INTENDED BENEFITS: TO TREAT LOCALISED PROSTATE CANCER

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

Temporary insertion of a bladder catheter and wound drain.
High chance of impotence due to unavoidable nerve damage.
No semen is produced during an orgasm, causing sub fertility.

OCCASIONAL

Blood loss requiring transfusion or repeat surgery.
Urinary incontinence, temporary or permanent, requiring pads or further surgery.
Discovery that cancer cells already outside the prostate needing observation or further treatment.
Further treatment at a later date if required, including radiotherapy or hormonal therapy.

RARE

Pain, infection or hernia in area of incision.
Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death).
Rectal injury, very rarely needing temporary colostomy.

ALTERNATIVE THERAPY

Watchful waiting, radiotherapy, brachytherapy, hormonal therapy and perineal or laparoscopic removal.

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: PLEASE TICK

- 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: _____