



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: TRANSURETHRAL INCISION OR RESECTION OF THE PROSTATE

THIS OPERATION INVOLVES THE TELESCOPIC REMOVAL OF OBSTRUCTING PARTS OF THE PROSTATE WITH A HEAT DIATHERMY OR LASER. TEMPORARY INSERTION OF A CATHETER FOR BLADDER IRRIGATION

INTENDED BENEFITS: RELIEF OF URINARY OBSTRUCTION AND IMPROVEMENT IN URINARY FLOW

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 mild burning, bleeding and frequency of urination after procedure.
No semen is produced during an orgasm in approx: 20% if incision or 75% if resection.
May not relieve all prostatic symptoms.

OCCASIONAL

Poor erections possible (impotence in approx 5-10%).
Infection of bladder or kidney requiring antibiotics.
Bleeding, requiring return to theatre and/or blood transfusion.
Possibly need to repeat treatment later due to re-obstruction (approx. 20%).
May need self catheterisation to empty bladder fully if bladder weak.
Failure to pass urine after surgery requiring a new catheter.

RARE

Finding unsuspected cancer in the removed tissue and this may need further treatment.
Injury to urethra causing delayed scar formation.
Loss of urinary control (incontinence), temporary or permanent.
Absorption of irrigating fluids causing confusion, heart failure (TUR Syndrome)
Very rarely, perforation of the bladder requiring a temporary urinary catheter or open surgical repair.

ALTERNATIVE TREATMENT Drugs, use of a catheter or stent, observation or open operation.

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: _____