CONSENT FORM 1

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Patient Agreement to Investigation or Treatment

1 Patient details (or pre-printed label)

Name: .....
Date of Birth: .....
Address: .....
.....
.....
District or NHS No.: .....

Special requirements *(eg other language/other commuincation method)*
.....
.....

2 Responsible Health Professional & Job Title:

.....
.....

3 Name of proposed procedure or course of treatment *(include brief explanation if medical term not clear)*

.....
.....
.....

4 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 in detail to the patient. In particular, I have explained:

The intended ***benefits:*** .....
Serious or frequently occurring ***risks***/hazards (potential complications of this procedure) including individual specific risks to the patient: .....
.....
Alternatives: .....
No Treatment: .....

Any extra procedures which may become necessary during the procedure

☐ blood transfusion

☐ other procedure (please specify) .....
.....

☐ X-rays/Radiation – I have explained the risks/ benefits of radiation including background radiation equivalence associated with the use of xrays in the theatre during the proposed procedure.

5 Written patient information (operation/procedure specific) – The following leaflet(s) has / have been offered:

Leaflet Title	Leaflet Code	Accepted (A) / Declined (D)

6 Anaesthesia – This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

7 Written patient information (anaesthesia) – The following leaflet(s) has/ have been offered:

Leaflet Title	Leaflet Code	Accepted (A) / Declined (D)

8 Copy accepted by patient: yes / no (please ring)

GOLD COPY: CASE NOTES **WHITE COPY: PATIENT**

9 Investigative Images, Clinical Photography and Video/ Audio Recordings (Conventional or Digital)

- I have explained that if any investigative images, photographic and/ or video/ audio recordings are required and made, they will be used for **clinical purposes** and form part of the patient's record ☐
- Additional uses of the above – Whether the patient can be identified or not, does the patient agree to any of the following (please circle): 1. Education **Yes / No / N/A** 2. Publication **Yes / No / N/A** 3. Research **Yes / No / N/A**
- ☐ I have explained that once any images are placed in the public domain the Trust may not be able to control future use.

10 Signature of Health Professional Gaining Consent

I am assured that the person giving consent has capacity to undertake this decision ☐

Signed: ..... Date .....

Name (PRINT) ..... Job title .....

11 Contact details for doctor/secretary (if patient wishes to discuss options with the doctor later):

.....

Alternatively the doctor may be contacted via the Patient Experience Team (PET)
PET King's Mill Hospital 01623 672222 PET Newark Hospital 01636 685692

12 Statement of interpreter (where appropriate)

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

☐ Face to Face Signed ..... Name (PRINT) ..... Date .....

☐ via Telephone Code ..... Name (PRINT) ..... Date .....

13 Statement of 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 agree** to the procedure or course of treatment described on 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.
- **I understand** that 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 patients 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 my life or to prevent serious harm to my health.
- **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.

.....
.....

Patient's Signature ..... Name (PRINT) ..... Date .....

14 Witness/Parent Signature (where appropriate)

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).

Witness/Parent Signature ..... Name (PRINT) ..... Date .....

15 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)

☐ For patients having their procedure/ treatment in the Operating Department: The Operating surgeon / Operating Practitioner has confirmed the consent **OR**

☐ For patients having their procedure/ treatment outside of the Operating Department: A member of the healthcare team who is part of the procedural team on the day has confirmed the consent

Signed ..... Date .....

Name (PRINT) ..... Job Title .....

16 Important notes: (tick if applicable)

☐ See also Advance Decision to Refuse Treatment

☐ Patient has withdrawn consent (ask patient to sign /date here) .....