**CONSENT FORM**

**for**

**TRANSRECTAL ULTRASOUND AND BIOPSY OF THE PROSTATE.**

**Patient Details or pre-printed label**

|  |  |
| --- | --- |
| **Patient’s NHS number of Hospital number** |  |
| **Patient’s surname/family name** |  |
| **Patient’s first names** |  |
| **Date of birth** |  |
| **Sex** | **MALE** |
| **Responsible health professional** |  |
| **Job Title** | **Consultant Urologist** |
| **Special requirements*****e.g. Other language/other communication method*** |  |

**To be retained in patients notes**

**Patient identifier/label**

## Notes Copy

|  |  |
| --- | --- |
| **Name of proposed procedure** | **ANAESTHETIC** |
| **Transrectal Ultrasound and Biopsies of the Prostate****(The taking of biopsies from the prostate gland via the back passage under ultrasound guidance)** | * **Local**
 |

**Statement of health professional** (To be filled in by health professional with appropriate knowledge of the proposed procedure, as specified in the consent policy) I have explained the procedure to the patient. In particular, I have explained:

**The intended benefits** To investigate the possibility of prostate cancer

**Serious or frequently occurring risks** I have discussed what the procedure is likely to involve, the benefits and risks of the investigation (including not having it done) and any particular concerns of this patient. Please tick the box once explained to the patient

# COMMON

INFECTION IN THE URINE REQUIRING ANTIBIOTICS

BLOOD IN THE URINE, STOOL OR SEMEN FOR SOME WEEKS

SOME DISCOMFORT FOLLOWING THE PROCEDURE THAT MAY REQUIRE MILD PAINKILLERS e.g. Paracetamol

### OCCASIONAL

NEED TO REPEAT THE PROCEDURE AT LATER DATE IF MORE INFORMATION IS REQUIRED

# RARE

SEPTICAEMIA (infection in the blood)

 **EXTREMELY RARE**

 DEATH

|  |  |
| --- | --- |
| **Signature of Health Professional** | **Job Title** |
| **Printed Name** | **Date** |

The following leaflet/tape has been provided

**Contact details** (if patient wishes to discuss options later)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of interpreter** (where appropriate) I have interpreted the information above to the patient to the best of my ability and in a way which I believe he can understand.

**Signature of interpreter**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print name: Date:

**Copy (i.e., page 3) accepted by patient: Yes/No**

**Patient identifier/label**

**Patient Copy**

|  |  |
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**Patient identifier /label**

Statement of patient

**Please read this form carefully.** If your investigation has been planned in advance, you should already have your own copy of page 2, which describes the benefits and risks of the proposed investigation. 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 proceduredescribed on this form
* to any tissue that is normally removed in this procedure could be stored and used for medical research (after the pathologist has examined it) rather than simply discarded. **PLEASE TICK IF YOU AGREE**

**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 any procedure in addition to the one 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. I have listed below any procedures which I do not wish to be carried out without further discussion. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of Patient**: |  | **Please print:** | **Date:** |

A witness should sign below if the patient is unable to sign but has indicated his consent.

 Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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). On behalf of the team treating the patient, I have confirmed with the patient that he has no further questions and wishes the procedure to go ahead.

|  |  |
| --- | --- |
| Signature of Health Professional | Job Title |
| Printed Name | Date |

Important notes: (tick if applicable)

 See also advanced directive/living will (e.g. Jehovah’s Witness form)

Patient has withdrawn consent (ask patient to sign/date here)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_