NHS
Salisbury
NHS Foundation Trust

Patient agreement to investigation or treatment for Defibrillator Threshold Testing (DFT)

Designed in compliance with the Department of Health Consent Form 1

Patient details (or pre-printed label)	
Patients NHS Number or Hospital Number	
Patients Surname / Family Name	
Patients First Name(s)	
Date of Birth	
Sex	
Responsible Healthcare Professional	
Job Title	
Special Requirements e.g. other language or other communication method	

Notes Copy

Patient identifier/label

Name of Proposed Procedure (include a brief explanation if medical term not clear)	**Anaesthetic**
Defibrillator threshold testing	❑ Sedation

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 assess integrity of defibrillator and recognise and treat rhythm disturbance

Significant, unavoidable or frequently occurring risks	initial
Stroke - less than 1 in 100	❑
Failure to defibrillate if the ICD does not correct the induced heart rhythm	❑
Musculoskeletal pain	❑
Minor skin injury - skin burns or irritation from the electrodes (patches)	❑
Death - very rare between 1 in 1000 and 1 in 10,000	❑

Any extra procedures which may become necessary during the procedure:

❑ blood transfusion

❑ other procedure (please specify).....

I have 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.

❑ The following leaflet / tape has been provided: Cardiac Defibrillator Threshold Test (DFT)

Signed:	Date:
Name (PRINT)	Job Title:

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 I believe s/he can understand.

Signature of Interpreter _____Name (print) _____ Date _____

Copy accepted by patient: yes / no (please ring)
This copy to be retained in patient's notes

Patient's copy

Patient identifier/label

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Patient's copy

Patient identifier/label

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2, 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 my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand 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. _____

_____

_____

Patient's signature	Name (PRINT)	Date:

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).

Signature	Name (PRINT)	Date:

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 s/he has no further questions and wishes the procedure to go ahead.

Signed:	Date
Name (PRINT)	Job Title

Important notes: (tick if applicable)

- ❑ See also advance decision to refuse treatment (e.g. Jehovah's Witness form).
- ❑ Patient has withdrawn consent (ask patient to sign/date here) _____
- ❑ Patient agrees to the use of surplus tissue (ensure signed consent in notes).

This page to be retained in patient's notes