**Surname:**

**First name:**

 **Date of birth:**

**Hospital no:**

(Use Hospital Identification Label)

***Consent Form 1***

**Patient Agreement to**

**Investigation or Treatment**

**Operative Vaginal Delivery**



Special patient requirements ……………………………………………………………………………………………………………………………………….

*(e.g., other language/other communication method)*

Responsible Healthcare Professional ……………………………………………………………………………………………………………………………

Job Title ……………………………………………………………………………………………………………………………………………………………………….

 **Name of proposed procedure or course of treatment Side/Site………...**……………………………………… (As appropriate)

(Include brief explanation medical term not clear)

**Operative Vaginal Delivery (vacuum-assisted delivery and/or forceps delivery)**

**Statement of health professional**

(To be filled in by health professional with an **appropriate knowledge of proposed procedure**, as specified in the Trust´s consent policy)

I have explained the procedure to the patient. In particular, I have explained:

**The intended benefit:** To secure the safest and/or quickest route of delivery of baby.

**Serious or frequently occurring risks to Mother Risks to Baby**

|  |  |
| --- | --- |
| * Vaginal/vulval/perineal tear

1 in 10 with vacuum and 1 in 5 with forceps * Postpartum haemorrhage, 1–4 in 10
* Third- and fourth-degree perineal tear

1– 4 in 100 with vacuum 8–12 in 100 with forceps delivery * Anal sphincter dysfunction/voiding dysfunction

**Any extra procedures which may become necessary:**  Manual rotation prior to instrument Episiotomy 5–6 in 10 for vacuum, 9 in 10 forceps Repair of perineal tear  Caesarean section Blood transfusion | * Forceps marks on face
* Chignon/cup marking on the scalp (practically all cases of vacuum-assisted delivery)
* Cephalhaematoma 1–12 in 100
* Facial or scalp lacerations, 1 in 10
* Neonatal jaundice /hyperbilirubinaemia, 5–15 in 100
* Retinal haemorrhage 17–38 in 100
* Subgaleal haematoma, 3–6 in 1000
* Intracranial haemorrhage, 5–15 in 10,000
* Facial nerve palsy – Rare risk
 |

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.

The following leaflet has been provided ….………………………………………………………………………………………………………………

**This procedure will involve:**

 General and/or regional anaesthesia Local anaesthesia Sedation

Signed ………………………………………………………………………………… Date…………………………………................................................

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

**Contact details** (If patient wishes to discuss options later) ………………………………………………………………………………………….

 **Statement of interpreter (If appropriate)**

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

Signed ………………………………………………………… Date…………………………………........................................

Name (PRINT) ……………………………………………………………………………………………………………………………………………………………….

Page **1** of **2**  **Copy accepted by patient: Yes / No (please ring)**

 **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, 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 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 ……………………………………………………………….…………… Date…………………………………................................

Name (PRINT) ……………………………………………………………………………………………………………………………………………………………...

**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).**

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 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 directive/living will (e.g. Jehovah´s Witness Form)Patient has withdrawn consent (ask patient to sign/date here)

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