

**Surname:**

**First name:**

**Date of birth:**

**Hospital no:**

(

Use Hospital Identification Label)

***Consent Form 1***

**Patient Agreement to**

**Investigation or Treatment**

**Repair of Third or Fourth Degree Perineal Tears**

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** ………………………………………….

 (Include brief explanation medical term not clear) (Delete as appropriate)

**Repair of third or fourth degree perineal tear following childbirth**

 **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 repair damage that has occurred during birth. To attempt to restore to normal anatomy, help wound healing and reduce the risk of long-term bowel problems.

**Frequent risks**

• Urinary infection (common), 1:10 to 1:100

• Wound infection (common), 8:100

• Perineal Pain and dyspareunia, 9:100

• Granulation tissue formation

• Migration of suture material requiring removal

• Fear, difficulty and discomfort in passing stools in the immediate PN period

**Serious risks**

• Inability to control flatus

• Inability to control leakage or solid faeces, 2:100 to 7:100

• Developing a rectovaginal fistula (hole between your back passage and vagina after the tear has healed)

• Haematoma

• Increased urgency to open bowels (rush to toilet) 26:100

• Failed repair requiring the need for further intervention in the future such as secondary repair or sacral nerve stimulation

**Any extra procedure which may become necessary during the procedure:**

  Blood transfusion

 A large vaginal dressing or tampon to be placed in the vagina for a few hours to stop bleeding.

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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