Salisbury NHS
NHS Foundation Trust

Patient agreement to investigation or treatment of Endovenous Treatment for Varicose Veins

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	

Tissue samples

Tissues may be removed during your procedure for diagnostic examination by a histopathologist (a specialist doctor who looks at tissue from patients). Tissue samples needed for diagnosis are stored by the laboratory for several years. The stored tissue may be anonymously used for laboratory quality control, audit and education. These are essential activities for maintaining high quality diagnostic pathology services. Any remaining excess tissue removed is incinerated.

The specimen may be digitally photographed and the images temporarily stored in the laboratory as part of the diagnostic process. Other completely anonymised images may also be used for quality assurance, audit and education purposes.

Occasionally stored tissues and photographs might be used for research projects. Any such research will have been approved by a local or regional research ethics committee (REC). Usually any pathology specimens used for research are made completely anonymous, so that individual patients cannot be identified in any way. If this is not possible, the REC will require the researcher to contact you and ask permission to use your stored tissue or photographs. You would then be free to decide whether or not to allow the use of the material. Your decision would not in any way affect your medical care.

Notes Copy

Patient identifier/label

Name of Proposed Procedure (include a brief explanation if medical term not clear)	**Anaesthetic**
Endovenous treatment of varicose veins	❑ General / regional ❑ Local ❑ 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 remove incompetent vein/prevent leg ulceration.

Serious or frequently occurring risks	
Deep vein thrombosis. (1:800)	❑
Pain and bruising.	❑
Temporary change in sensation of the lower leg	❑
Recurrence of veins. (1:20 in five years)	❑
	❑

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: Endovenous treatment

Signed:	Date:
Name (PRINT)	Job Title:

Contact Details (if patient wishes to discuss options later): 01722 429219

Statement of interpreter (where appropriate). I have interpreted the information above 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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Signature of Interpreter _____ Name (print) _____ Date _____

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 advanced directive/living will (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