

Patient agreement to investigation or treatment

PATIENT DETAILS OR LABEL

Surname:

Responsible health professional:

First name(s):

Job title:

Date of birth:

Male Female

Special requirements:
(e.g. other language/
other communication method)

NAME AND SITE OF PROPOSED PROCEDURE OR COURSE OF TREATMENT:

(Include brief explanation if medical term not clear)

STATEMENT OF HEALTH PROFESSIONAL

To be filled in by a health professional with an **appropriate knowledge of the 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 benefits of the procedure _____

• Any significant, unavoidable or frequently occurring risks from the procedure _____

I have discussed what the treatment / 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 information leaflet has been provided:

I have offered the patient information about the procedure but she/he has declined information.

This procedure will involve: General and/or regional anaesthesia Local anaesthesia Sedation

Health professionals signature:

Date:

Name (PRINT):

Job title:

STATEMENT OF THE INTERPRETER (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe she/he can understand.

Interpreter's signature:

Date:

Name (PRINT):

COPY ACCEPTED BY PATIENT: YES/ NO (please circle)

Patient agreement to investigation or treatment

STATEMENT OF PATIENT

PATIENT IDENTIFIER/LABEL

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 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.

PLEASE TICK THE BOXES IF YOU AGREE/ UNDERSTAND THE FOLLOWING STATEMENTS

- I agree to the procedure or course of treatment described on this form.
- I confirm that Dr Krishna has explained the procedure to me in detail and has given me opportunity to ask questions and clarify any doubts related to my procedure and over all treatment.
- I confirm that Dr Krishna has also discussed alternative management options that may be relevant to my case.
- I confirm that the following side effects** have been explained to me:
- Failure:** There is no guarantee that the procedure may work.
- Flare up of pain:** My pain can flare up for a few days and some times up to a few weeks following injection treatment. This is usually related to steroid content of the injection.
- Bruising:** I may have some bruising at the site of the injection.
- Infection:** I may develop infection at the site of injection. This is a rare complication but can be serious, depending on the site of injection.
- Bleeding:** I may develop bleeding at the site of injection. This is a rare complication but can be serious, especially in patients taking blood-thinning medications.
- Nerve injury:** Injection treatment can cause serious nerve injury, which can lead to minor or major disability. This is a rare but serious complication of injection treatment.
- I understand that photos and video may be taken during my surgery as part of my ongoing care.

Patient's signature:

Date:

Name (PRINT):

SIGNATURE OF WITNESS (if appropriate)

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:

Date:

Name (PRINT):

CONFIRMATION OF CONSENT (if appropriate)

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.

Signature:

Date:

Name (PRINT):

Job title: