North East Wales NHS Trust

Radical Orchidectomy (+/- Silicone Implant) Consent Form

Surname	
First name	
NHS/hospital no.	
Date of birth	
	_____/_____/_____

Special communication requirements (e.g. need for interpreter, visually impaired)	

Proposed procedure or course of treatment: (include brief explanation if medical term not clear)
Radical Orchidectomy (+/- Silicone Implant). Side_____. Removal of the testis for suspected testicular cancer via a groin incision

Other procedures/treatment which may become necessary during the procedure:	To deal with complications if they occur
Anaesthetic: ❒General ❒Spinal ❒Local	**Blood transfusion:** If bleeding excessive

Statement of health care professional (to be filled in by health care professional with appropriate knowledge of proposed procedure, as specified in Consent Policy)

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

Benefits: the intended benefits of this procedure/treatment are:

- To treat testicular cancer

Risks: Occasional

- Need for additional procedures or treatments such as surgery, radiation or chemotherapy
- Cancer, if found, may not be cured alone
- Permission to biopsy other side if small, abnormal or history of maldescent
- Loss of future fertility

Rare

- Removal of testes only to find that cancer was not present
- Possibility that pathologic diagnosis will be uncertain
- Infection of incision requiring further treatment (& possible removal of implant)
- Bleeding requiring further surgery (& possible removal of implant)

If insertion of testicular prosthesis

- Pain, infection or leaking requiring removal of implant
- Implant may lie higher in scrotum than normal testis
- Long term risks from use of silicone products unknown
- Patient cosmetic expectations not always met
- Palpable stitch at one end which you may be able to feel

Alternatives: I have also discussed what the procedure is likely to involve and any concerns of this patient. I have also discussed having no treatment and the following alternatives:

-
-

Further supporting information - I have provided the following leaflet _____

Signature……..……..Name (PRINT)……..Date___/___/_____

Job title……Contact Details……..……..

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient, to the best of my ability, and in a way in which I believe they can understand.

Signature……..……..Name (PRINT)……Date___/___/_____

Confirmation of consent by a health professional on admission of the patient, 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……..……..Name (PRINT)……..Date___/___/_____

Job title……

One copy of this form must be retained in the Health Record
- another copy has / has not been accepted by the patient.

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Surname	
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	_____/_____/_____

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 agree** that any tissue removed and the results of diagnostic tests may be used for teaching, audit and research that could benefit other patients.
- **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.
  ……
  ……
  ……
  ……

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___/___/_____

Important Notes: (tick if applicable)

☐ See also advance directive/living will

☐ Patient has withdrawn consent (ask patient to sign /date here)

Signature……..Name (PRINT)…… …Date___/___/_____

One copy of this form must be retained in the Health Record
- another copy has / has not been accepted by the patient.