North East Wales NHS Trust

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

Radical Retropubic Prostatectomy and Pelvic Lymph Node Dissection Consent Form

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 Retropubic Prostatectomy and Pelvic Lymph Node Dissection. Removal of the whole prostate gland, seminal vesicals and draining nodes for cancer,as well as tying of the Vas Deferens. Incision in lower half of abdomen.

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 localised prostate cancer

Risks: Common

- Temporary insertion of a bladder catheter and wound drain
- High chance of impotence due to unavoidable damage
- No semen is produced during an orgasm causing sub fertility

Occasional

- Blood loss requiring transfusion or repeat surgery
- Urinary incontinence temporary or permanent requiring pads or further surgery
- Discovery that cancer cells already outside prostate needing observation or further treatment
- Further treatment at a later date if required including radiotherapy or hormonal therapy

Rare

- Anaesthetic or cardiovascular problems possibly requiring intensive care admission (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)
- Pain, infection or hernia in area of incision
- Rectal injury, very rarely needing temporary colostomy

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:

- Watchful waiting. Radiotherapy. Brachytherapy.
- Hormonal Therapy and Perineal or Laparoscopic removal

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.

North East Wales NHS Trust

Radical Retropubic Prostatectomy and Pelvic Lymph Node Dissection Consent Form

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

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.