NHS Ayrshire & Arran

Example form only
–
Not for Use

Write or attach label
CHI No:
Surname:
Forename:
Address:

Date of Birth:
Sex:

Consent for Operation

PROCEDURE: .....
.....
.....
PURPOSE OF PROCEDURE: .....
SIDE OF PROCEDURE: LEFT / RIGHT / BOTH / NOT APPLICABLE

A. Statement of health professional

I confirm I am a health professional with an **appropriate knowledge of the proposed procedure** as specified in the Board's consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) ☐ the proposed approach

b) ☐ the intended benefits of the procedure

c) ☐ the possible risks of the procedure (including those specific to the patient)

d) ☐ the benefits and risks of any alternative treatments (including no treatment) and any particular concerns of the patient

e) any additional procedures that might become necessary during surgery. Commonly this would include:

☐ Blood transfusion ☐ Other procedure (please state)

.....
.....
.....
NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I have provided an information leaflet to explain the benefits and risks of, and alternatives to the proposed treatment.

Yes ☐ Leaflet title: ..... Leaflet version no.: .....

No ☐ It is the health professional's responsibility to document the benefits, risks and alternatives explained to the patient.

.....
.....
.....
.....
.....

☐ In my view, this patient has capacity at this time to consent to this procedure. Where the clinician has doubts about capacity, please refer to the consent policy for guidance on Adults with Incapacity, and section 47 certificate of incapacity.

Consultant or other responsible health professional

It is the responsibility of the doctor undertaking the procedure to personally seek patient consent. In the unusual event that this is not practical, the responsibility can be delegated to another professional, but that individual must be suitably trained and qualified, have sufficient knowledge of the proposed investigation or treatment, understand the risks involved and act in accordance with the Board's consent policy.

As the health professional explaining this procedure, please confirm:

☐ I am fully familiar with the procedure, its risks, benefits and alternatives.

Signed (health professional): ..... Date: .....
Name (PRINT): ..... Time (24 hr): .....
Designation: ..... GMC/GDC/NMC number: .....

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B. Consent of patient, parent or guardian

I understand the information given to me, including the risks, benefits and alternatives to this operation. The information has been discussed with me, and my questions have been answered in a way I could understand. I accept that the doctor has told me:

- ☐ my expected outcome and the risks of having the operation
- ☐ the benefit this operation may bring to me, but also that this cannot be guaranteed even though performed with professional care
- ☐ other relevant treatment options and their associated risks
- ☐ that an appropriately qualified doctor, undergoing further training, may perform the operation
- ☐ that I have the right to change my mind at any time before the operation, including after I have signed this form

If an emergency occurs, I may require other procedures, but these will only be carried out to save my life or to prevent serious harm to my health. I have listed below any procedures that **I do not wish to be carried out without further discussion:**

☐ Blood transfusion ☐ Other procedure (please state)

.....
.....

NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I understand the benefits, risks and alternatives that have been explained to me, and I agree to the operation.

Signed (patient/parent/guardian): ..... Date: .....

Name of patient/parent/guardian (PRINT): .....

Relationship to patient: .....

C. Confirmation of consent (for use on day before or day of surgery)

Confirmation of consent is only mandatory, when the original consent was signed by the patient >84 days before the date of the operation.
On behalf of the team treating the patient, I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Consultant or other responsible health professional

Signed (health professional): ..... Date: .....
Name (PRINT): ..... Time (24 hr): .....
Designation: ..... GMC/GDC/NMC number: .....

Patient

Signed (patient/parent/guardian): ..... Date: .....

Name of patient/parent/guardian (PRINT): .....

Relationship to patient: .....