

Consent Form

INGUINAL HERNIA REPAIR

Patient Agreement to Investigation or Treatment

K_917_617

NH: FAWCETT, STEPHEN
16 FOLGATE ROAD
HEACHAM
Pat KING'S LYNN
NORFOLK, PE31 7BN
Dat M NO M 24/10/1967
NH: DR LR MOTWANI
494 237 3395

Details (or pre-printed label)

Patient's first names.....
Responsible health professional MISS. GEOGLONAN
Job title CONSULTANT
Special requirements.....
(eg other language/other communication method)

Male Female

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)
LAPAROSCOPIC +/- OPEN MESH REPAIR OF INGUINAL HERNIA

RIGHT OR LEFT OR BOTH SIDES
(PLEASE CIRCLE ONLY ONE, IN CASE OF ERROR USE ANOTHER FORM)

Statement of health professional (to be filled in by health 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 intended benefits **IMPROVE SYMPTOMS/ PREVENT POTENTIAL COMPLICATIONS**



Serious or frequently occurring risks

BLEEDING (BRUISING/ SWELLING/ DISCOLOURATION OF THE GROIN/LEG/ GENITALIA), INFECTION (REDNESS/ SWELLING/DISCHARGE FROM THE WOUNDS), RECURRENCE OF HERNIA (1-5 IN 100 CASES), NUMBNESS IN THE LEG /GROIN/ PERINEAL AREA, INJURY TO OTHER ORGANS i.e. (VESSELS, VISCERAS, BOWEL), TESTICULAR ATROPHY, DISCOMFORT/ PAIN AFTER SURGERY, CHRONIC PAIN (PROLONGED PAIN LASTING MONTHS/YEARS), SCAR AT INCISION SITE, URINARY RETENTION, BLOOD CLOTS IN THE LEG OR LUNGS, RISKS OF GENERAL ANAESTHESIA

Any extra procedures which may become necessary during the procedure

- blood transfusion **VERY RARELY NEED BLOOD TRANSFUSION,**
- other procedure (please specify) **MAY NEED FURTHER SURGERY IN CASE OF SIGNIFICANT COMPLICATIONS. MAY NEED PART OF THE BOWEL REMOVED**

I have also 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 GS 12

This procedure will involve:

- general and/or regional anaesthesia
- local anaesthesia
- sedation

Signed..... Date 12/06/2024

Name (PRINT) I. GEOGLONAN Job title CONSULTANT

Contact details (if patient wishes to discuss options later) MISS. GEOGLONAN'S secretary

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 s/he can understand.

Signed..... Date.....

Name (PRINT).....

Copy accepted by patient: **yes** / no (please ring)

Yellow Copy: CASE NOTES White Copy: PATIENT