Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
FRENULOPLASTY THIS IS THE SURGICAL TREATMENT FOR A SHORT FRENULUM	☐ - GENERAL/REGIONAL ☐ - LOCAL ☐ - SEDATION

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 TO TREAT FRENULAR ABNORMALITY

Serious or frequently occurring risks including any extra procedures, which may become necessary during the procedure. 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. Please tick the box once explained to patient

OCCASIONAL
- ❑ INFECTION OF CUT REQUIRING FURTHER TREATMENT AND CASUALTY VISIT
- ❑ BLEEDING OF THE WOUND OCCASIONALLY NEEDING A FURTHER PROCEDURE AND CASUALTY VISIT
- ❑ FURTHER NEED FOR CIRCUMCISION IF FAILS TO IMPROVE SYMPTOMS.
- ❑ PERSISTENCE OF ABSORBABLE STITCHES AFTER 3 / 4 WEEKS REQUIRING REMOVAL AT GP

RARE
- ❑ ALTERED SENSATION OF PENIS
- ❑ SCAR TENDERNESS, RARELY CHRONIC
- ❑ YOU MAY NOT BE COMPLETELY COSMETICALLY SATISFIED
- ❑ FURTHER NEED FOR CIRCUMCISION IF FAILS TO IMPROVE SYMPTOMS.

ALTERNATIVE THERAPY: CIRCUMCISION, OBSERVATION.

A blood transfusion may be necessary during procedure and patient agrees **YES or NO (Ring)**

Signature of Health Professional	Job Title
Printed Name	Date

The following leaflet/tape has been provided

Contact details (if patient wishes to discuss options later) _____

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.

Signature of interpreter: Print name: Date: