

Patient identifier/label

Patient Copy

<p align="center">Name of proposed procedure (Include brief explanation if medical term not clear)</p>	<p align="center">ANAESTHETIC</p>
<p><u>HYDROCELE REPAIR</u> SIDE.....</p> <p>THIS IS THE REMOVAL OR REPAIR OF FLUID SAC SURROUNDING TESTICLE</p>	<p><input type="checkbox"/> - GENERAL/REGIONAL <input type="checkbox"/> - LOCAL <input type="checkbox"/> - SEDATION</p>

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 SCROTAL SWELLING CAUSED BY FLUID COLLECTION

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

- RECURRENCE OF FLUID COLLECTION CAN OCCUR
- BLOOD COLLECTION AROUND TESTES WHICH RESOLVES SLOWLY OR REQUIRES SURGICAL REMOVAL.
- POSSIBLE INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

ALTERNATIVE THERAPY: OBSERVATION, REMOVAL OF FLUID WITH A NEEDLE, VARIOUS OTHER SURGICAL APPROACHES

COPY FOR PATIENTS

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

<p>Signature of Health Professional</p>	<p>Job Title</p>
<p>Printed Name</p>	<p>Date</p>

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.

<p>Signature of interpreter:</p>	<p>Print name:</p>	<p>Date:</p>
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