

Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
SIMPLE (Millin's) RETROPUBIC PROSTATECTOMY REMOVAL OF OBSTRUCTING PORTION OF PROSTATE GLAND THROUGH ABDOMINAL INCISION WHEN THE PROSTATE GLAND IS TOO BIG TO REMOVE WITH THE TELESCOPIC METHOD	<input type="checkbox"/> - GENERAL/REGIONAL <input type="checkbox"/> - LOCAL <input type="checkbox"/> - 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

RELIEF OF URINARY OBSTRUCTION AND IMPROVEMENT IN URINARY FLOW

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

COMMON

TEMPORARY INSERTION OF A BLADDER CATHETER AND WOUND DRAIN

NO SEMEN IS PRODUCED DURING AN ORGASM CAUSING SUBFERTILITY

OCCASIONAL

FREQUENCY OF URINATION MAY PERSIST AFTER SURGERY

BLEEDING REQUIRING FURTHER SURGERY OR TRANSFUSIONS

10% CHANCE OF IMPOTENCE (POOR ERECTIONS)

RARE

FINDING OF UNSUSPECTED CANCER REQUIRING FURTHER TREATMENT

INFECTION, PAIN OR HERNIA OF INCISION REQUIRING FURTHER TREATMENT

INCONTINENCE OF URINE (POOR URINARY CONTROL) TEMPORARY OR PERMANENT

VERY RARELY,

ANAESTHETIC OR CARDIOVASCULAR PROBLEMS POSSIBLY REQUIRING INTENSIVE CARE ADMISSION (INCLUDING CHEST INFECTION, PULMONARY EMBOLUS, STROKE, DEEP VEIN THROMBOSIS, HEART ATTACK AND DEATH.)

ALTERNATIVE THERAPY: DRUGS TO SHRINK OR OPEN THE PROSTATE, LONG TERM CATHETER DRAINAGE, TELESCOPIC REMOVAL OF PROSTATE OBSTRUCTION

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: