

Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
<u>INSERTION OF TESTICULAR PROSTHESIS</u> SIDE..... THIS INVOLVES THE INSERTION OF A SILICONE /SALINE TESTICULAR IMPLANT VIA A GROIN INCISION	<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

COSMETIC SATISFACTION

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

MAY RIDE UP IN WARM WEATHER

PALPABLE STITCH AT ONE END WHICH YOU MAY BE ABLE TO FEEL

OCCASIONAL

COSMETIC RESULT IS NOT ALWAYS PERFECT

RARE

INFECTION OF INCISION REQUIRING FURTHER TREATMENT & POSSIBLE REMOVAL OF IMPLANT

BLEEDING FROM WOUND REQUIRING SURGERY & POSSIBLE REMOVAL OF IMPLANT

PAIN, INFECTION OR LEAKING REQUIRING REMOVAL OF IMPLANT.

LONG TERM UNKNOWN RISKS FROM USE OF SILICONE PRODUCTS

ALTERNATIVE THERAPY: NO PROSTHESIS

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: