Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
TESTES BIOPSY (+/- STORAGE OF TISSUE) SIDE.......... THIS IS THE REMOVAL OF SMALL PIECE OF TESTICULAR TISSUE THROUGH A SCROTAL INCISION	☐ - 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 DIAGNOSIS OF TESTICULAR PROBLEM OR FERTILITY TREATMENT

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
- ❑ WE CANNOT GUARANTEE FUTURE FERTILITY
- ❑ IF STORING TISSUE, CHECK THAT THE APPRORIATE FORMS HAVE BEEN SIGNED

OCCASIONAL
- ❑ INFECTION OF INCISION REQUIRING FURTHER TREATMENT
- ❑ INCONCLUSIVE DIAGNOSIS FROM BIOPSY

RARE
- ❑ DAMAGE TO TESTICLE, EPIDIDYMIS OR VAS FROM BIOPSY
- ❑ RARELY, CHRONIC PAIN IN TESTICLE OR SCROTUM

ALTERNATIVE TREATMENT: OBSERVATION, MEDICAL TREATMENTS

COPY FOR PATIENTS

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: