Patient identifier/label

Patient Copy

| Name of proposed procedure<br>(Include brief explanation if medical term not clear) | ANAESTHETIC |
|---|---|
| **BRACHYTHERAPY TREATMENT FOR PROSTATE CANCER**<br><br>INSERTION OF RADIOACTIVE SEEDS INTO THE PROSTATE GLAND WITH NEEDLES PLACED IN THE SKIN BENEATH THE SCROTUM. THIS PROCEDURE MAY REQUIRE CYSTOSCOPY. | ☐ - GENERAL/REGIONAL<br>☐ - LOCAL<br>☐ - 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 LOCALISED PROSTATE CANCER

**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
- ❑ DIFFICULTY PASSING URINE AFTER THE PROCEDURE USUALLY TEMPORARY
- ❑ FREQUENCY AND URGENCY OF URINATION
- ❑ NEED TO SELF CATHETERISE TEMPORARILY WHILE SWELLING SETTLES

OCCASIONAL
- ❑ CHANCE OF IMPOTENCE DUE TO UNAVOIDABLE NERVE DAMAGE FROM THE SEEDS
- ❑ FURTHER TREATMENT AT A LATER DATE IF REQUIRED INCLUDING SURGERY AND / OR HORMONAL THERAPY

RARE
- ❑ INFECTION OF BLADDER REQUIRING ANTIBIOTICS
- ❑ BLEEDING AND SWELLING OF PROSTATE PREVENTING URINATION
- ❑ URINARY INCONTINENCE TEMPORARY OR PERMANENT
- ❑ PASSAGE OF SEED IN URINE OR MIGRATION OF SEEDS OUT OF PROSTATE
- ❑ OCCASIONAL NEED FOR SURGERY TO PROSTATE IF DIFFICULTY PASSING URINE
- ❑ RECTAL DAMAGE REQUIRING TEMPORARY COLOSTOMY

ALTERNATIVE THERAPY: WATCHFUL WAITING, EXTERNAL BEAM RADIOTHERAPY, RADICAL PROSTATECTOMY (OPEN OR LAPAROSCOPIC) AND HORMONAL THERAPY.



**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: