Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
PENILE STRAIGHTENING (NESBITTS) THIS IS A PROCEDURE TO CORRECT PENILE CURVATURE	☐ - 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 TO CORRECT THE CURVE IN YOUR PENIS

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
- ❑ THERE IS SOME SHORTENING OF PENIS
- ❑ POSSIBLE DISSATISFACTION WITH COSMETIC OR FUNCTIONAL RESULT
- ❑ TEMPORARY SWELLING AND BRUISING OF PENIS AND SCROTUM

OCCASIONAL
- ❑ CIRCUMCISION IS SOMETIMES REQUIRED AS PART OF PROCEDURE
- ❑ NO GUARANTEE OF TOTAL CORRECTION OF BENDING
- ❑ RECURRENCE OF CURVE AT LATER TIME
- ❑ BLEEDING OR INFECTION REQUIRING FURTHER TREATMENT

RARE
- ❑ IMPOTENCE OR DIFFICULTY MAINTAINING ERECTIONS CAN OCCUR AFTERWARDS
- ❑ NERVE INJURY WITH TEMPORARY OR PERMANENT NUMBNESS OF PENIS

ALTERNATIVE TREATMENT: OBSERVATION, DRUGS AND OTHER SURGICAL APPROACHES

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: