Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
RADICAL ORCHIDECTOMY (+/- SILICONE IMPLANT) SIDE……. REMOVAL OF THE TESTIS FOR SUSPECTED TESTICULAR CANCER VIA A GROIN 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 TO TREAT TESTICULAR 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

OCCASIONAL
- ❑ CANCER, IF FOUND, MAY NOT BE CURED BY THIS ALONE
- ❑ NEED FOR ADDITIONAL PROCEDURES OR TREATMENTS SUCH AS SURGERY, RADIATION OR CHEMOTHERAPY
- ❑ LOSS OF FUTURE FERTILITY
- ❑ PERMISSION TO BIOPSY OTHER SIDE IF SMALL, ABNORMAL OR HISTORY OF MALDESCENT

RARE
- ❑ REMOVAL OF TESTES ONLY TO FIND THAT CANCER WAS NOT PRESENT
- ❑ POSSIBILITY THAT PATHOLOGIC DIAGNOSIS WILL BE UNCERTAIN
- ❑ INFECTION OF INCISION REQUIRING FURTHER TREATMENT (&POSSIBLE REMOVAL OF IMPLANT)
- ❑ BLEEDING REQUIRING FURTHER SURGERY (&POSSIBLE REMOVAL OF IMPLANT)

IF INSERTION OF TESTICULAR PROSTHESIS
- ❑ PAIN, INFECTION OR LEAKING REQUIRING REMOVAL OF IMPLANT.
- ❑ PATIENT COSMETIC EXPECTATIONS NOT ALWAYS MET
- ❑ IMPLANT MAY LIE HIGHER IN SCROTUM THAN NORMAL TESTIS
- ❑ PALPABLE STITCH AT ONE END WHICH YOU MAY BE ABLE TO FEEL
- ❑ LONG TERM RISKS FROM USE OF SILICONE PRODUCTS UNKNOWN

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: