Patient identifier/label

Parent/child copy

| Name of proposed procedure<br>(Include brief explanation if medical term not clear) | ANAESTHETIC |
|---|---|
| SIMPLE ORCHIDECTOMY SIDE…….<br><br>THIS INVOLVES REMOVAL OF TESTIS VIA A GROIN OR A SCROTAL INCISION | ☐ - 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 child and his or her parent(s). In particular, I have explained:

**The intended benefits**

TO TREAT TESTICULAR ABORMALITY

**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 and his or her parents Please tick the box once explained to child/parents

OCCASIONAL
- ❑ INFECTION OF INCISION REQUIRING FURTHER TREATMENT
- ❑ BLEEDING FROM WOUND REQUIRING SURGERY
- ❑ WE CAN NOT GUARANTEE FUTURE FERTILITY

RARE
- ❑ FINDING OF UNSUSPECTED DIAGNOSIS ON THE HISTOLOGY EXAMINATION REQUIRING FURTHER TREATMENT

ALTERNATIVE THERAPY MAY INCLUDE: OBSERVATION



**A blood transfusion** may be necessary during procedure and parent agrees **YES or NO (Ring)**

| Signature of Health Professional | Job Title |
|---|---|
| Printed Name | Date |

**The following leaflet/tape has been provided**

**Contact details** (if child/parents wish to discuss options later) _____

**Statement of interpreter** I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

| Signature of interpreter: | Print name: | Date: |
|---|---|---|