Patient identifier/label

Parent/child copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
ORCHIDOPEXY SIDE………. THIS INVOLVES AN INCISION IN THE GROIN AND THE SCROTUM TO BRING THE TESTIS DOWN INTO THE CORRECT POSITION	☐ - 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 child and his or her parent(s). In particular, I have explained:

The intended benefits

TO BRING TESTIS DOWN INTO SCROTUM

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
- ❑ RARELY, INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT
- ❑ OCCASIONALLY THE TESTIS WILL REMAIN HIGH IN THE SCROTUM AFTERWARDS
- ❑ OCCASIONALLY NOT POSSIBLE TO BRING DOWN

RARE
- ❑ BLEEDING REQUIRING FURTHER TREATMENT
- ❑ RARELY, THE TESTIS CAN SHRINK DUE TO POOR BLOOD SUPPLY AFTER THIS CONDITION

VERY RARE
- ❑ WE CAN NOT GUARANTEE FUTURE FERTILITY
- ❑ VERY RARELY THE PROCEDURE NEEDS TO BE REPEATED

ALTERNATIVE THERAPY: OBSERVATION

COPY FOR PARENTS

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: