Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
AMPUTATION OF PENIS, PARTIAL OR COMPLETE **+/- REMOVAL OF GROIN NODES** AMPUTATION OF PART OR ALL OF THE PENIS FOR CANCER WITH FORMATION OF NEW URETHRAL OPENING TO ALLOW URINATION	☐ - 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 PENILE 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 AND WOUND DRAIN
- ❑ DIFFICULTY IN DIRECTING URINARY STREAM OR NEED TO SIT DOWN TO PASS URINE
- ❑ SIGNIFICANT AMOUNT OF PENILE SHORTENING IF PARTIAL / LOSS OF WHOLE PENIS IF COMPLETE
- ❑ INABILITY TO HAVE SEXUAL INTERCOURSE BECAUSE OF SHORTENING OR ERECTILE FAILURE

OCCASIONAL
- ❑ NEED TO CONVERT A PARTIAL TO A COMPLETE IF CANCER MARGIN SEEMS INCOMPLETE.
- ❑ BLEEDING REQUIRING FURTHER SURGERY OR RARELY, TRANSFUSIONS
- ❑ RECURRENCE OF CANCER IN STUMP OF PENIS
- ❑ NEED OF FURTHER THERAPY FOR CANCER (SURGERY, RADIATION, CHEMOTHERAPY)

RARE
- ❑ SKIN FAILING TO HEAL REQUIRING FURTHER SURGERY.
- ❑ INFECTION, PAIN OF INCISION REQUIRING FURTHER TREATMENT
- ❑ NARROWING OF URINARY OPENING NEEDING FURTHER TREATMENT
- ❑ MAY BE ABNORMALITY OTHER THAN CANCER ON MICROSCOPIC ANALYSIS

ALTERNATIVE THERAPY: RADIATION OR TOPICAL DRUGS / CONSERVATIVE SURGERY

IF REMOVAL OR GROIN NODES
- ❑ PROLONGED FLUID DRAINAGE FROM GROIN SITE
- ❑ INFECTION OF GROIN SITE
- ❑ MILD SWELLING OF LEGS / ANKLES

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: