

Patient identifier/label

Patient Copy

Name of proposed procedure (Include brief explanation if medical term not clear)	ANAESTHETIC
TRANSURETHRAL RESECTION OF BLADDER TUMOUR THIS INVOLVES THE TELESCOPIC REMOVAL OF BLADDER TUMOUR WITH HEAT DIATHERMY	<input type="checkbox"/> - GENERAL/REGIONAL <input type="checkbox"/> - LOCAL <input type="checkbox"/> - 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 DIAGNOSE AND TREAT LESION IN BLADDER SUSPICIOUS FOR MALIGNANCY

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

- MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION
- TEMPORARY INSERTION OF A CATHETER FOR BLADDER IRRIGATION
- NEED FOR ADDITIONAL TREATMENTS TO BLADDER IN ATTEMPT TO PREVENT RECURRENCE OF TUMOURS INCLUDING DRUGS INSTALLED INTO THE BLADDER

OCCASIONAL

- INFECTION OF BLADDER REQUIRING ANTIBIOTICS
- NO GUARANTEE OF CANCER CURE BY THIS OPERATION ALONE
- RECURRENCE OF BLADDER TUMOUR AND/OR INCOMPLETE REMOVAL

RARE

- DELAYED BLEEDING REQUIRING REMOVAL OF CLOTS OR FURTHER SURGERY
- DAMAGE TO DRAINAGE TUBES FROM KIDNEY (URETERS) REQUIRING ADDITIONAL THERAPY
- INJURY TO URETHRA CAUSING DELAYED SCAR FORMATION
- PERFORATION OF THE BLADDER REQUIRING A TEMPORARY URINARY CATHETER OR OPEN SURGICAL REPAIR

ALTERNATIVE THERAPY: OPEN SURGICAL REMOVAL OF BLADDER, CHEMOTHERAPY OR RADIATION THERAPY

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:
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