

CONSENT FORM

Patient details (or pre-printed label to be attached to both copies)

Patient's surname/family name

Date of birth

NHS number/UBRN

Male Female

Responsible health professional and job title

Special requirements
(eg other language/other communication method)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

- Bilateral Vasectomy

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

- Permanent contraception – requires follow-up with semen analysis 12 & 14 weeks after operation

Serious or frequently occurring risks

- Failure of procedure (1:200) that can be early or late following operation
- Bleeding and/or bruising (haematoma occurs in 5% of cases)
- Infection
- Irreversible procedure
- Penile and/or testicular pain (occurs in 5-15% of cases)

Any extra procedures which may become necessary during the procedure

- Blood transfusion
- Other procedures (please specify)

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.

The following leaflet has been provided:Vasectomy.....

This procedure will involve:

Local Anaesthetic General and/or regional Anaesthetic Sedation

Signed:.....

Date:.....

Name (PRINT).....

Job Title:.....

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.

Signed:..... Date:.....

Name (PRINT).....

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

.....
.....

Patient's signature Date:.....

Name (PRINT)

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature Date

Name (PRINT)

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature..... Date ..

Name (PRINT) Job Title.....

Important notes: (tick if applicable)

See also advance directive/living will (eg Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign /date here)

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