Simple orchidectomy consent form

This form should only be used if the patient has capacity to give consent. If support is required with consent (interpreter, witness, carer, guardian, parent, or any other relevant support) please ensure they are present. If the patient does not legally have capacity, please use an appropriate alternative consent form from your hospital or hub. This form will be the result of a shared decision conversation between a clinician and patient. "You / your / me / my" hereby refers to the patient.

Please note it is common NHS practice for your consent to be taken by a clinician other than the operating or listing surgeon. This clinician will be suitably trained and competent to take consent. They will be referred to as the "responsible healthcare professional" in this form.

You will be provided with additional patient information about your procedure by your hospital or hub site. These will be provided in a language and format that suits you.

You may have questions before starting, during or after your procedure. Contact details are provided for any further queries, concerns or if you would like to discuss your treatment further. The risks quoted in this consent form for surgery assume that you have no additional factors which would increase your risk. The clinician discussing the consent with you will explain if you have health conditions or factors that may increase your risk.

Your details (Print or sticker)

First name:

Last name:

Date of birth:

NHS or Hospital number:

Responsible Health Professional:

My requirements: e.g, transport, interpreter, assistance

Details of Simple orchidectomy

Simple orchidectomy Procedure:	This procedure involves the removal of your testicle through a groin or scrotal incision with the option to insert a testicular implant (prosthesis). The term 'simple' means a procedure is not being performed for a suspected cancer.
Site and side: (Tick as appropriate)	☐ **Left** ☐ **Right**
Indication for, and purpose of surgery / benefits: (Tick as appropriate)	☐ **To remove a testicle which has been damaged or shrunken in size** ☐ **Other(s)** _____
Alternatives considered: (Tick as appropriate)	☐ **Observation** – no treatment, but monitoring of any change in your symptoms; symptoms can improve over time without any treatment. ☐ **Other(s)** _____

Patient name: _____ **NHS or Hospital number:** _____

Possible late or long-term risks

Expected Will probably happen	**Discomfort** Swelling, discomfort and bruising of your scrotum.
Common Might happen (more than 1 in 20)	**Dissatisfaction with final cosmetic result** There may be asymmetry between the new testis prosthesis and your other testicle. The prosthesis may sit higher in the scrotum, be less mobile and be a slightly different size and consistency to your other testicle. **Discomfort** You may be able to feel the 'fixation' stitch at one end of the prosthesis through the skin.
Uncommon Unlikely to happen (fewer than 1 in 20)	**Infection** Infection or bleeding in the incision requiring further treatment (and possible removal of the prosthesis). **Fertility** Loss or reduction of fertility. **Pain** Persistence of chronic pain in your scrotum despite removal of the testicle. **Numbness** Persistence of numbness in the groin and / or scrotum.
Rare Probably won't happen (fewer than 1 in 100)	**Problems with prosthesis** Pain, infection, bleeding or leaking of the implant requiring further treatment including removal of the prosthesis. Unknown long-term risks associated with the use of silicone-based products.

Patient name: _____ **NHS or Hospital number:** _____

Patient specific risks

Patient Specific Risks	

Patient specific concerns

If you have any **specific concerns or personal risks** to you from your treatment, you can record them here. Please use this space to **record any concerns around allergies / reactions** and also any life saving **procedures that you do not wish to be carried out** without further discussion.

Any extra procedures which may become necessary during the procedure:

☐ Blood transfusion:

☐ Other procedures (please specify): _____

Patient name:

NHS or Hospital number:

Statement of healthcare professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

– I am suitably trained and competent and have sufficient knowledge to consent this patient in line with the requirements of my regulatory body.
– I have discussed what the treatment is likely to involve, the benefits and risks of this procedure.
– I have discussed the benefits and risks of any available alternative procedures or treatments including no treatment.
– I have considered any additional patient-specific factors and discussed these with the patient alongside their particular concerns.
– I can confirm that the patient has the capacity to give consent.

Patient information leaflet provided: ☐ Yes / ☐ No – Details:

Copy of consent form accepted by patient: ☐ Yes / ☐ No

Name:

Job title:

Date:

Signature:

Statement of patient

Please read this form carefully. 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.

You must consent to the following section to proceed with your surgery:

– I confirm that I have read and understood pages 1 to 5 of the consent form.
– I understand the diagnosis and agree with the course of treatment described on this form.
– I have had the opportunity to discuss treatment alternatives, including no treatment.
– I have had the purpose, aims and possible risks of treatment explained to me.
– I understand that the operating person, who will have appropriate expertise to carry out the procedure, may not have been involved in my pre-operative assessment or care to date.
– I understand my anaesthetic options will be or have been discussed with an anaesthetist where we will jointly decide which option is best for me. I understand that the type of anaesthesia may need to be altered if there are any complications during the procedure.
– I have been told about additional procedures which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks, photographs, and / or tissue samples to help with treatment planning and identification.
– 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 spoken to my health care professional about any lifesaving procedures I do not wish to happen.
– I understand that relevant and appropriate patient specific data for this procedure will be collected and may be used in the context of providing clinical care, and/or audit purposes in compliance with Data Protection Act (2018).

Statement of: interpreter witness

(where appropriate)

☐ I have interpreted the information contained in this form to the patient to the best of my ability and in a way in which I believe they can understand.

or

☐ I confirm that the patient is unable to sign but has indicated their consent.

Name:

Signature:

Additional Consent: ***This section will not stop you from receiving surgery but will help with future learning and training.*** **Please tick if you consent:**

☐ I understand that there may be health care professionals that are training during my procedures such as medical students, and trainee nurses. I consent that they may participate in examinations relevant to my procedure, supervised by a fully qualified professional.

☐ I understand that information collected during my procedure including images, may be used for education and research (which may be published in medical journals). All information will be anonymised and used in a way that I cannot be identified.

☐ I agree that my health records may be used by authorised members of staff, who are not directly involved in my clinical care, for research approved by a research ethics committee and in compliance with the Data Protection Act (2018).

Tick if relevant: ☐ I confirm that there is no risk that I could be pregnant.

Name:

Date:

Signature:

Patient name: **NHS or Hospital number:**

Anaesthesia

Anaesthetic is used to allow surgery to take place painlessly. It may include medicines which put you to sleep or those which only numb the area you are having operated on while you remain awake. This can be done in a variety of ways and your anaesthetist will advise you on your options and talk to you about the risks, complications, and benefits of types of anaesthetic. If there are particular anaesthetic risks/concerns for any particular patient these should be separately documented in the patient's records.

Anaesthetic options and risks will be discussed with you on the day of surgery with an anaesthetist. This is a shared decision-making process, and you will jointly decide and agree which anaesthetic option is best for you. Please remember that if there are any complications during surgery, your anaesthetist may need to alter the type of anaesthesia and will explain this to you before the procedure.

For further information about the types of anaesthetic you may receive, and potential risks please see information below.

Types

Risks

https://www.rcoa.ac.uk/documents/anaesthesia-explained/types-anaesthesia

https://www.rcoa.ac.uk/patient-information/patient-information-resources

If you do not wish to access the additional patient information via link or QR code, please speak to your clinician and they will provide you with a hard copy. These will be provided in a language and format that suits you.

To be filled out by Anaesthetist (On day of surgery)

Name of Anaesthetists on the day: **Date:**

☐ I confirm I have discussed the different anaesthetic options with the patient, including risks and benefits and we have jointly decided what the preferred anaesthetic is.

Please note the preferred method of Anaesthesia as discussed between the patient and anaesthetist below:

Signature:

To be filled out by your responsible healthcare professional (On day of surgery)

Reconfirmation of consent / Withdrawal of consent (where appropriate)

Reconfirmation of consent: ☐ Withdrawal of consent: ☐ See advance decision to refuse treatment: ☐

Name: **Date:**

Signature:

The responsibility for informed consent is between the patient and the consenting clinician and the NHS trust. NHS England, Getting It Right First Time (GIRFT) and associated organisations are supplying this resource which should be used/amended by the clinician as they see fit according to their clinical judgement. NHS England, GIRFT and associated organisations do not accept any liability for the consent collected using this resource or the subsequent treatment including surgical and additional procedures.