

## Patient agreement to investigation or treatment

# Total hip arthroplasty (replacement)

**Authors: Department of Trauma and Orthopaedics**

**Brief description:**

- We hope this will give you an understanding of your hip-replacement surgery. Please use this only as a guide, and keep in mind that individuals vary in their progress.
- A total hip replacement replaces a worn-out hip joint, which has usually been damaged by arthritis, or occasionally by another cause. The hip joint is a ball and socket joint, formed by a socket in the pelvis (the acetabulum) and a ball on the head of the thighbone (femur). Over many years the smooth covering (cartilage) of the joint may be worn away, exposing the underlying bone and the joint becomes arthritic. The joint can then become very painful with restricted movement. Arthritis is more common in older people.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital.**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website:  
<http://www.addenbrookes.org.uk/consent>.
- Guidance for healthcare professionals can be found on the Trust's intranet:  
<http://nww.addenbrookes.nhs.uk/consent>.
- Remember, you can change your mind about having the procedure at any time.

**For staff use:**

Does the patient have any special requirements? (e.g. interpreter or other communication method.)

.....

.....

---

## **Name of procedure: Total hip arthroplasty (replacement)**

### **Intended benefits of the procedure**

- The aim of surgery is to improve your quality of life, primarily by relieving your pain. If your hip is stiff, the range of movement may also improve, but this is not always the case. Replacement hip surgery is considered by some to be one of the greatest surgical revolutions in the past few decades. However as hip replacement surgery is a major operation, we usually recommend that you consider this only if your pain is severe, your walking distance is restricted and simple painkillers do not afford you relief. By this stage, you might need to use a stick to help you walking.

### **What types of hip replacement are there?**

- There are many different hip replacement components in use, but the principles of the procedure are all similar. There are two main components used: an acetabular cup to replace the worn socket, a stem to replace the worn ball of the femur, which is the long bone of the thigh. The acetabular cup may be made of a high-density plastic and the stem is made of metal. Most hip replacements are held in place with special bone cement.
- There are variations from this. Sometimes an acetabular cup with a metal backing is used, without cement. This metal acetabular cup has a porous surface, for bone in-growth, that holds it in place. The cup is then lined with polythene. Similarly, a femoral stem may be used which does not require cement and attaches itself to the bone.
- Generally a metal ball will articulate on a polythene surface, to form the new hip joint itself. Sometimes a ceramic ball is used with the polythene socket, or occasionally a ceramic lined metal socket can be used with a ceramic ball. Another alternative is an all metal hip replacement, or a 'resurfacing' hip replacement.

### **Before the operation**

#### **The Pre-Admission Assessment Clinic**

- You will often be seen a few weeks before surgery by a nurse, physiotherapist, occupational therapist and other members of the Surgical Team in a Pre-Admission Assessment Clinic at the hospital. This appointment will give you an opportunity to discuss any queries with the staff present. Various blood tests, a urine test, an electrocardiogram (an ECG or electrical recording of your heart), perhaps a chest or further hip X-ray, etc will be taken.
- Plans for your care at home, after discharge from surgery, will also be discussed.
- At this time the physiotherapist and occupational therapist will ask you about your home situation, measure you for crutches and advise you about various aids that will help you after the operation (such as a toilet seat raise, bath board, 'helping hand', long shoe horn). You will also be taught how to use crutches. Please bring details of your medication to this appointment. You may be offered a video to help you prepare for surgery and your recovery.
- If you are a smoker, your post-operative recovery will be greatly enhanced if you stop smoking two weeks before surgery. Smoking makes anaesthesia difficult and leaves you prone to chest infection or circulatory problems after surgery.

### **Admission to hospital**

- You will be admitted to hospital shortly before the operation, usually the afternoon before, and will be seen by the ward staff and anaesthetist. Please ensure you bring all

your medication, toiletries, clothing, etc. You will be unable to eat or drink for six hours before surgery.

- Please make sure you tell your GP you will be in hospital, as they may be able to help you prepare for coming home again and may wish to visit you after discharge.
- Generally you should continue all your medication until admission to hospital. Some patients take "low-dose aspirin" for chest pain or to prevent a small stroke or TIA - typically a low dose of 75mg (half a junior aspirin). If you are taking low-dose-aspirin, you should continue taking this as usual until the time of your admission (unless your medical team advises otherwise) and low-dose-aspirin will probably continue immediately after surgery. If you are on a higher dose of aspirin please discuss this in the Pre-Admission Clinic.
- One exception to continuing your regular medication, is if you are taking non-steroidal anti-inflammatory drugs (NSAIDs) such as stronger aspirin, Brufen™, Nurofen™ (Ibuprofen) Voltarol™ (Diclofenac) and Naprosyn™ (Naproxen). These affect your blood-clotting factors. You should stop taking these drugs for at least 10 days before surgery and use alternative painkillers.
- Some patients with rheumatoid arthritis take a drug called methotrexate, which may need to be stopped a week or so before surgery. Some diabetic drugs (such as Metformin) need to be stopped a couple of days before surgery too. Please seek further advice about these drugs in the pre-admission clinic.
- Many patients receive an injection or tablets (called anticoagulants) to reduce the risk of a blood clot (thrombosis) forming in the leg around the time of surgery.

### During the operation

- The anaesthetist will prescribe medication to help you feel sleepy and relaxed before you go to theatre.
- Surgery will be performed under a general anaesthetic and/or regional anaesthetic (a spinal injection to numb your legs and help with pain relief). Further information on your anaesthetic can be found on page 7 of this form. The operation itself usually takes a couple of hours, but you will not be back on the ward for at least three to four hours because you will spend some time in the recovery room, which is next to the operating theatres.

### After the operation

- After your operation, you will wake up in the recovery room. You might have an oxygen mask on your face to help you breathe; you might also wake up feeling sleepy, both of which are normal.
- You may have a triangular pillow between your legs.
- You may have a small, plastic tube in one of the veins in your arm. This is often attached to a drip (bag of fluid), which gives you fluid and antibiotics. Additional pain relief or a blood transfusion can also be given through this drip.
- While you are in the recovery room, a nurse will check your pulse and blood pressure regularly. When you are well enough to be moved, you will be taken to your ward. Sometimes, people feel sick after an operation and might actually vomit. If you feel sick, please tell a nurse and you will be given some medicine to try and stop the sickness/vomiting.
- You may have one or two drains (tubes) coming from your wound. These are attached to a bottle and for a few hours after surgery collect the fluid that seeps from the operating site. Some patients also have a urinary catheter (a tube into the bladder) for a while.

- You may be wearing 'anti-embolism stockings', which reduce the risk of blood clotting in the legs by improving their circulation. If used, you should wear these for two to three weeks after you are discharged home.
- Initially, you will have some pain, but this will be controlled either by giving you painkillers through the drip or once you are able to eat and drink, with injections or tablets.

## Progress after surgery

- Everybody recovers at different speeds, dependent on your age, your general health and the nature of your surgery. As soon as you wake up after surgery and are able to, you should start wiggling your toes and feet, bending your foot up and down, ten times every half an hour. This helps the circulation in your calf. You can try to bend your knee gently. You will be allowed to sit up at approximately 40° in bed. For the first few days, you should do regular deep breathing exercises, to keep your lungs expanding, and to prevent a chest infection.
- The wound is covered with a white absorbent or clear plastic dressing. Sometimes, fluid accumulates under this dressing, which can be easily drained. Sutures (stitches) underneath the skin may be used and do not need to be removed. Sometimes metal staples are used, which are removed after you have returned home, around 12 days after surgery.
- The day after surgery, the drain tubes will be removed, if drains have been used. The physiotherapist will visit you and help you to stand, and possibly, walk on your new hip. On the second day, the physiotherapist will get you walking with crutches.
- You will soon be able to get out of bed and sit in a high chair and use the toilet with a raised seat. At this stage, you must not sit on a low chair. This is because it would allow your hip to bend too far and could dislocate the new hip. When you are in the hospital bed, you should also keep the triangular pillow between your legs.
- Until you are ready for discharge home, you will be encouraged to be as independent as possible with the help of the nurses and physiotherapists. Please think about your home environment before you leave hospital and discuss any problems with the occupational therapist, medical staff, nursing staff, or physiotherapist.

## Going home

- Most patients can go home about four to six days after surgery, some go home at an earlier stage. Before this, arrangements can be made for the loan, hire or purchase of certain aids, including a toilet seat raise, a shower chair, walking frame, crutches, walking sticks and a gadget to help you put on your surgical stockings, socks and shoes. If you have stairs, the physiotherapist will teach you to climb these before you leave hospital.
- If you live alone, it is very helpful if a friend or relative can stay at home with you for a week or so after discharge. If your bed is upstairs, you may wish to consider bringing the bed downstairs initially. If access to a toilet is difficult, possibly a house commode would be helpful. You will also need someone to help you with domestic chores and you may have difficulty getting to the shops, so will need someone to do your shopping.
- Once you are home, you must continue with the exercise regime as discussed with the physiotherapist. Initially, have a half-hour lie down on your bed twice a day because this will help stretch your hip. For the first six weeks sleep with a pillow between your legs and lie on your back when you sleep. For the first eight weeks always try to get out of bed on the same side as your operated hip.
- When you are sitting, never let your knee be higher than your hip level. This can cause

your hip to bend too far and may dislocate (pop out of joint). Likewise, when you get up out of a chair, push up from the arms without leaning too far forward.

- It is advisable to go for regular daily walks. As the days go by, you will be able to walk greater distances. For the first six weeks, you should expect to walk with two and subsequently one crutch for support. Some people are able to walk without the support of crutches at an earlier stage.
- You will be seen in clinic about six weeks after surgery, when you will be able to discuss your progress and any problems.
- You can start driving when you have adequate control of your leg, which is usually about six to eight weeks after your surgery. You must, however, inform your car insurance company that you have an artificial hip.

### As you progress

- Even in the long-term, many people find a walking stick helpful after a joint replacement (which you need to hold in the opposite hand). Continuing to use a walking stick is by no means a disgrace - many people find it helps to boost their confidence.
- The most difficult part of your recovery is the first few days following surgery. You will also find it difficult for the first few days when you get home. The most rapid improvement is expected in the first six weeks, but you will continue getting an improvement, with your hip feeling more comfortable, your range of movement improving, and your confidence improving, for several months. Many patients report progressive improvement for twelve months or more after the operation.
- Even in the long-term, there is a small risk your hip can dislocate (pop out of joint). Remember always to sit on a chair with your hip higher than your knees. Try to sit down with your legs slightly apart. Do not cross your legs. Be careful sitting in a bath and preferably use a shower, especially for the first few months after surgery.

### Serious or frequently occurring risks

- A hip replacement is usually a very successful operation. Over 90% of our patients come into hospital, have the operation, go home again and have no further problems. The decision to have any surgery should not be taken lightly because there are some risks. The most common of which are:
- **Infection:** There is a risk of infection following this operation. Infection is a rare complication despite careful surgical techniques and the use of preventative antibiotics. Some infections can be serious and, on a few occasions, the artificial joint replacement will need to be removed.
- **Blood clotting:** Blood can clot in the legs following any surgery especially after operations that leave you less mobile. You may be given special stockings (anti embolism stockings) to wear to help combat this. Occasionally, a blood clot can break off and go to the lungs (an embolism), which can cause breathing problems.
- **Chest & urinary tract infections:** These are common risks to all surgical procedures. You can try and prevent a chest infection with breathing exercises.
- **Dislocation:** There is a risk of your hip dislocating after surgery (2 to 3% of cases). This is most common in the early stages following surgery and may be caused by crossing your legs, twisting badly on your leg, or sitting in a low chair. Usually a brief anaesthetic is required to get the hip back into joint. On rare occasions, the hip might need to be operated on again (revision surgery) to treat this problem.
- **Leg length:** We try and aim that your legs will be of equal length following surgery, but some variation is common and sometimes the leg is lengthened. This is usually not

noticeable but, occasionally, heel or sole raises are needed. Many patients have had unequal leg length for some years, to which they have become accustomed.

- **Nerve damage:** The major nerves around your hip can occasionally be stretched and damaged during the operation, which can lead to weakness and loss of feeling in your thigh, foot or leg.
- **Stroke and major chest problems, such as a small heart attack:** These are very occasional, but very serious consequences of any major surgery.
- **Swelling:** It is common for your leg and ankle to be a little swollen for some time after surgery. This gradually improves over a period of weeks or months. If you are concerned about this after discharge from hospital, you should see your GP or specialist again.
- **Other medical problems.** Major surgery can sometimes be followed by other unexpected medical problems including a heart attack, stroke or a fatal medical problem, poor kidney function, the gut temporarily failing to function, constipation, poor bladder function, *etc.*
- **Loosening, wear and long term failure:** All hip replacements are subject to wear in time. Failure of the new hip is usually caused by loosening of the components which rarely actually break. Loosening is a progressive problem, over many years. As a rough guide, 10% of hip replacements fail within 10 years of surgery, but around 80% are still functioning well after 15 years.
- **Anaesthesia,** both general and regional, for any operation carries risks of its' own. These risks are small, but can be significant, and will be discussed with you by the anaesthetist when they see you before the operation.

### Other points to remember

1. **Sitting.** As already mentioned, avoid sitting in low chairs. When you stand up from a chair, keep your operated leg in front of you, and take the weight through your unoperated leg. You should shuffle forwards to the edge of the chair before attempting to stand and push up with your arms. Sitting down is the reverse progress of standing, gently lowering yourself to the front of your chair, taking weight through your unoperated leg. Remember not to cross your legs when sitting.
2. **Sleeping.** Sleep on your back for the first six weeks following surgery, keeping the pillow between your legs at night during this period. Later on it is usually better to sleep on your operated leg.
3. **Getting out of bed.** Get out of bed on the same side as your operation if possible. Again, standing up from bed is similar to standing up after sitting in a chair. If your bed is very low, you may need to have a higher bed.
4. **Driving.** It is easier to drive a large or two-door car and have the seat as far back as possible. Gently lower yourself into the car, taking weight through your unoperated leg, keeping your operated leg straight in front of you. You can start driving again, usually six to eight weeks following surgery. You must be able to do an emergency stop. You should inform your insurance company before you start driving.
5. **Sexual intercourse.** You can enjoy normal sexual activity soon after surgery. Remember that you must not bend your hip further than a right angle, or 90°, but it is usually safe to let your knees roll out. Initially it is best for you to be on your back, but as time goes by, you will be able to become more adventurous.
6. **Toilet seat raise.** You should continue to use this for three months after surgery.
7. **Socks and shoes.** If you have difficulty putting on shoes or stockings, use a long-handled shoehorn, or a special gadget, which is available from the physiotherapist.
8. **Sports and hobbies.** Unless you have particular problems, you can re-start hobbies

such as gardening, bowling, gentle dancing, golf and swimming around three months after surgery. Contact sports should be avoided, as should vigorous exercise. It is best to avoid breaststroke while swimming because of the hip movements involved.

## Revision surgery

As already mentioned, a few hip replacements run into early problems. Some hip replacements wear out at a later date, requiring a re-do of the replacement. Further surgery is described as "revision surgery".

Revision surgery is complicated and the nature of surgery required is different in every case. However, the general principles of surgery are exactly the same, although the duration of surgery and the post-operative recovery is more prolonged. The general plan of post-operative mobilisation, care and precautions are often identical. Sometimes it is necessary to avoid weight bearing for the first few weeks and keep you walking with crutches for longer. Unfortunately, as a revision procedure is a more major operation, the potential complications are also greater.

## Useful contact numbers

The occupational therapists and physiotherapists can advise you about obtaining a toilet seat raise, walking aids, commodes, shoe and stocking gadgets. Some of these they can supply, others may need to come from the Red Cross.

Red Cross - Cambridge	Tel: 01223 357 376
Red Cross - Bury St Edmunds	Tel: 01284 767 215
Red Cross - Huntingdon	Tel: 01480 453 629
Red Cross - Ely	Tel: 01353 664 147

## Your anaesthesia

Your surgery will be performed under general and / or regional anaesthesia. Your anaesthetist will discuss this with you before surgery.

### General Anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation.

### Before your operation

Before your operation your anaesthetist will visit you in the ward, although occasionally this will happen in a pre-anaesthetic assessment clinic. The anaesthetist who looks after you on the day of your operation is the one who is responsible for making the final decisions about your anaesthetic. He or she will need to understand about your general health, any medication that you are taking and any past health problems that you have had. Your anaesthetist will want to know whether or not you are a smoker, whether you have had any abnormal reactions to any of the drugs or if you have any allergies. They will also want to know about your teeth, whether you wear dentures, have caps or a plate. Your anaesthetist needs to know all these things so that he or she can assess how to look after you in this vital period. Your anaesthetist may examine your heart and lungs and may also prescribe medication that you will be given shortly before your operation, the pre-medication or 'pre-med'.

**Pre-medication** is the name given to medication (drugs) given to you some hours before your operation. These drugs may be given as tablets, injections or liquids (to children). They relax you and may send you to sleep. They are not always given.

Do not worry if you do not have a pre-med, your anaesthetist has to take many factors into account in making this decision and will take account of your views on the topic if possible.

Do not be worried about your anaesthetic. When your anaesthetist visits you before your operation, this is the time to ask all the questions that you may have, so that you can forget your fears and worries.

Before your operation you will usually be changed into a gown and wheeled to the operating suite into an anaesthetic room. This is an ante-room outside the theatre. The anaesthetist, his or her assistant and nurses are likely to be present. An intravenous line (drip) may be inserted. Monitoring devices may be attached to you, such as a blood pressure cuff or a pulse oximeter. A pulse oximeter is usually a little red light in a small box, which is taped to your finger. It shows how much oxygen you have in your blood and is one of the vital monitors that an anaesthetist uses during your operation to ensure that you remain in the best of health. You may be given some oxygen to breathe.

### **During your operation**

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you in the correct level of unconsciousness for the period of the surgery. Your anaesthetist is constantly aware of your condition and trained to respond. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement. If you have any other medical conditions, your anaesthetist will know of these from your pre-operative assessment and be able to treat them during surgery.

### **After your operation**

After your operation your anaesthetist continues to monitor your condition carefully. You will probably be transferred to a recovery ward where specially trained nurses, under the direction of anaesthetists, will look after you. Your anaesthetist and the recovery nurses will ensure that all the anaesthetic effects are reversed and that you are closely monitored as you return to full consciousness. You may be given some oxygen to breathe in the recovery area, and may find that intravenous drips have been inserted whilst you are unconscious in theatre and that these will be replacing fluids that you might require. You will be given medication for any pain that you might feel, and systems, such as Patient Controlled Anaesthesia (PCA) may be set up to continue pain control on the ward.

You are likely to feel drowsy and sleepy at this stage. Some patients feel sick, others may have a sore throat related to the insertion of the breathing tube during surgery. During this time it is important that you relax as much as you can, breathe deeply, do not be afraid to cough, and do not hesitate to ask the nursing staff for any pain relief, and about any queries you may have. You are likely to have hazy memories of this time and some patients experience vivid dreams. Once you are fully awake you will be returned to the ward, and if you are a day patient will be allowed to go to the waiting area to fully recover before you are accompanied home. Do not expect to feel completely normal immediately!

### **Regional Anaesthesia**

For regional anaesthesia a local anaesthetic drug is injected around a bundle of nerves so that a part of the body, such as an arm or a leg, is made numb. In addition, the muscles in the limb are paralysed whilst the drug is acting so that the limb becomes floppy. Obviously you will still be awake and know that the operation is taking place, but often the anaesthetist will administer a sedative drug so that you drift off to sleep during the operation. Even if this is not the case, you will not be able to see the operation because a screen will be placed in the way.

Examples of regional anaesthesia are the use of an epidural for pain relief during

childbirth, a spinal for an operation on the bladder, hip or knee, and an eye block for cataract surgery. Sometimes regional and general anaesthesia are combined, particularly for major surgery, to provide pain relief after the operation. Just as for General Anaesthesia, your anaesthetist remains with you throughout the operation under regional anaesthesia, monitoring and controlling your anaesthetic state throughout in the same way. Similarly, you will go to the recovery ward afterwards until you are stable and safe to go back to the ward.

This document is also available in other languages, large print and audio format upon request – 01223 216032

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

#### Cantonese

આ દસ્તાવેજ વિનંતી કરવાથી બીજી ભાષાઓ, મોટા છાપેલા અક્ષરો અથવા ઓડિઓ રચનામાં પણ મળી રહેશે.

#### Gujarati

A richiesta questo documento è anche disponibile in altre lingue, a caratteri grandi e in formato audio.

#### Italian

ئەم بەلگەيە ھەر ھەروەھا بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەوێت

#### Kurdish

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

#### Urdu



# Patient agreement to investigation or treatment

<b>For staff use only:</b>
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:
(Use hospital identification label)

Responsible health professional/job title

.....

Special requirements .....  
(eg other language/other communication method)

## Name of proposed procedure or course of treatment

Total hip arthroplasty (replacement)      Side (left/right).....

## Statement of health professional

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- How it will be performed
- The intended benefits of the procedure
- Any serious or frequently occurring risks including those specific to the patient .....

- Any extra procedures that might become necessary during the procedure

Blood transfusion  
 Other procedure (please specify) .....

I have discussed what the treatment / 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 information leaflet has been provided: .....
- ..... Version/Date/Ref: .....

This procedure will involve:

General and/or regional anaesthesia       Local anaesthesia       Sedation

**Health professional's signature** ..... Date: .....

Name (PRINT): ..... Job title: .....

Contact details (if patient wishes to discuss details later) .....

I have offered the patient information about the procedure but s/he has declined information.

## Important notes: (tick if applicable)

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

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

## Statement of the interpreter (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature ..... Date: .....

Name (PRINT): .....

Copy accepted by patient: yes / no (please circle)

<b>For staff use only:</b> <b>Surname:</b> <b>First names:</b> <b>Date of birth:</b> <b>Hospital no:</b> <b>Male/Female:</b> <b>(Use hospital identification label)</b>
---

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which described the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please tick boxes to indicate you understand and either agree/disagree to the statements below.**

- |   |                          | Yes | No                       |
|---|--------------------------|-----|--------------------------|
| <b>I agree</b> to the procedure (or course of treatment) described on this form.  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I understand</b> that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I agree</b> that any tissue (including blood) removed as part of the procedure or treatment may be used for diagnosis and audit, stored or disposed of as appropriate and in a manner regulated by appropriate, ethical, legal and professional standards.   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I agree</b> that tissue (including blood) not needed for my own diagnosis or treatment can be used for the following purposes that could benefit other patients.   |                          |     |                          |
| <b>Teaching</b>   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>Research which may include genetic research</b>  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I understand</b> that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I understand</b> that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I agree</b> to the use of photography for the purpose of diagnosis and treatment.  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I agree</b> to anonymised photographs being used for medical teaching.   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I understand</b> 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.) | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I understand</b> 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.   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| <b>I have been told</b> about additional procedures which may become necessary during my treatment. I have listed below any procedures that <b>I do not wish, without further discussion, to be carried out.</b>  | <input type="checkbox"/> |     | <input type="checkbox"/> |

.....  
 .....

**Patient's own signature:** ..... **Date:** .....

Name (PRINT): .....

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

**Witness's own 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:** .....