NATIONAL ORTHOPAEDIC HOSPITAL CAPPAGH

Hip Arthroplasty Surgery Consent Form ≥ 18 Years

Addressograph
Name/MRN if addressograph not available

Section 1 is to be completed by the Practitioner. Section 2, located overleaf, must be completed by the Patient/Legal Decision-Making Representative after Section 1 has been filled out.

SECTION 1: FOR COMPLETION BY THE CONSULTANT OR NOMINATED PRACTITIONER

Procedure: (No abbreviations) _____

_____

_____

Side/Site:_____ **Estimated Length of Surgery:** _____

I CONFIRM THAT I HAVE CONDUCTED THE FOLLOWING CHECKS:

The patient's name and date of birth, procedure and site/side has been verified by the patient and/or legal decision-making representative. ☐

The correct side/site has been marked as per NOHC procedure for Safe Surgery PP-NOHC-21. ☐

The patient has been provided with the relevant information and leaflet(s) (as appropriate) for: ☐

Procedure ☐ Blood Transfusion ☐ Anesthetic Information

Consent ☐ Other: _____

I CONFIRM THAT I HAVE EXPLAINED TO THE PATIENT, LEGAL DECISION-MAKING REPRESENTATIVE/CO-DECISION MAKER/HEALTHCARE REPRESENTATIVE ALL OF THE INFORMATION BELOW IN TERMS, WHICH I BELIEVE THEY UNDERSTAND:

a) The diagnosis/ condition; ☐
b) The above investigation/ treatment/ operation/ procedure; ☐
c) The potential benefits of the operation/ procedure ☐
d) Any appropriate alternatives to the operation/ procedure; ☐
e) The likelihood of success of the proposed operation/ procedure; ☐
f) A Transfusion of blood/ blood products may be needed during the operation/ procedure. ☐
g) The risks associated with the operation including, but not limited to, chronic pain, scar, bleeding, infection, stiffness, nerve/blood vessel/bone injury (fracture), implant failure, leg length discrepancy, dislocation, blood clots in legs and/or lungs, cardiovascular event, permanent disability, need of continued medical therapy and death. Additional risks discussed: ☐

_____

_____

_____

_____

Practitioner's Signature: _____ **Date:** _____ **Time:** _____

Practitioner's Name in Block Capitals_____ **MCRN:**_____

Practitioner's Title: _____

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SECTION 2: FOR COMPLETION BY THE PATIENT/LEGAL DECISION-MAKING REPRESENTATIVE AFTER SECTION 1 HAS BEEN COMPLETED

ABOUT CONSENT
A person must consent before any medical procedure, test, or examination. Where an adult is assessed as lacking the capacity to consent to a procedure, their legally appointed legal decision-making representative must provide consent. A designated healthcare representative can only consent when an advance care directive (AHD) is in place. A registered co-decision maker can counter-sign the consent form with the patient upon request, once they have been present for the consent discussion. In all of these cases, written evidence of the agreements must be provided.

INFORMED CONSENT
In preparation for treatment, staff have shared details about your condition, treatment options, and the risks and benefits of treatment. This form asks if you have enough information to make an informed decision.

PURPOSE OF CONSENT FORM
A signed consent form documents what was explained, discussed and agreed with the patient and legal decision-making representative and how consent was given.

CONSENTING TO RESEARCH & EDUCATION
NOHC is a training hospital where students observe or participate in patient care under supervision. We also conduct research to improve treatment. Signing this consent form indicates your agreement to these practices.

a) I have checked that the details on this form are correct. ☐

b) I have listened to and understand the explanation given for the operation/ procedure. ☐

c) I understand that the operation/ procedure carries with it risks to life and health, may not have the expected benefit or outcome and that unanticipated complications may arise. ☐

d) I understand that the practitioner who obtained this consent from me may not carry out the operation/procedure. ☐

e) I have had the opportunity to ask questions about anaesthesia and read the Patient Information Leaflet on Anaesthesia (if applicable) ☐

f) I have had the opportunity to ask questions about my procedure and read the Patient Information Leaflet specific to my procedure. ☐

g) I know that I can ask for clarification of anything that I do not understand. ☐

h) I am aware that NOHC is a teaching hospital and as such students/ trainees/ NCHDs/ medical science representatives may be involved/ present during my treatment process and that some or all of my procedure may be carried out by healthcare professionals under supervision as part of their training. ☐

i) I am aware that in emergent situations, it may not be possible to obtain consent and care/treatment may be provided as is necessary to save my life, or prevent serious harm to my health. I also understand that any procedure, in addition to that described on this form, will only be carried out if it is necessary and in my best interests and justified for medical reasons. I have told the doctor about any additional procedure, which I would NOT wish to be carried out without my having the opportunity to consider them first. Specific here any procedure (if any): ☐

_____

j) I understand that I may withdraw my consent at any time, including during treatment, by notifying the doctor and that I have the right to a second opinion. ☐

k) I understand that during the procedure, it may be necessary to take x-rays, photographs or digital recordings for the purpose of treating or assessing me. ☐

I consent to the **OPERATION/ PROCEDURE** described: ☐
I consent for **ANAESTHESIA**, including Monitored Anaesthesia Yes ☐ No ☐ Care Regional ☐ & General ☐, as required.
I consent for **BLOOD/ BLOOD PRODUCTS.** ☐

Patient/Legal Decision-Making Representative/Designated Healthcare Representative

Signature: _____ Date: ___/____/____ Time: ____:____

For Co-Decision Maker only - Required in addition to patient signature:

Signature:_____ Date: ___/____/____ Time: ____:____

Witness to verbal consent*:_____ Date: ___/____/____ Time: ____:____
*must be an NOHC Representative