



Surname	
First name	
NHS/hospital no.	
Date of birth	____/____/____

Extracorporeal Shockwave Lithotripsy
ESWL Consent Form

Special communication requirements (e.g. need for interpreter, visually impaired)	
Proposed procedure or course of treatment: (include brief explanation if medical term not clear)	Extracorporeal Shockwave Lithotripsy ESWL. Side _____ This involves the administration of shockwaves through the skin to fragment urinary tract stones into small enough fragments to pass naturally. This will be done under X-ray or Ultrasound control.
Other procedures/treatment which may become necessary during the procedure:	To deal with complications if they occur
Anaesthetic: <input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Local	Blood transfusion: If bleeding excessive

Statement of health care professional (to be filled in by health care 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 following.

Benefits: the intended benefits of this procedure/treatment are:

- To treat urinary tract stones

Risks: Common

- Bleeding on passing urine for a short period after procedure
- Pain in the kidney as small fragments of stone pass after fragmentation
- Urinary tract infection from bacteria released from the stone when fragmented needing antibiotic treatment

Occasional

- Stone may be too hard to break – requiring alternative treatment
- Repeated ESWL treatments may be required
- Recurrence of stones

Rare

- Kidney damage (bruising) or infection needing further treatment
- Stone fragments occasionally getting stuck in the tube between the kidney and the bladder requiring hospital attendance and sometimes surgery to remove the stone fragment
- Severe infection requiring intravenous antibiotics and sometimes drainage of the kidney by a small drain placed through the back into the kidney

Alternatives: I have also discussed what the procedure is likely to involve and any concerns of this patient. I have also discussed having no treatment and the following alternatives:

- Telescopic surgery. Open surgery or observation to allow spontaneous passage

Further supporting information – I have provided the following leaflet /tape _____

Signature.....Name (PRINT).....Date ____/____/____

Job title.....Contact Details.....

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 they can understand.

Signature.....Name (PRINT).....Date ____/____/____

Confirmation of consent by a health professional on admission of the patient, 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.....Name (PRINT).....Date ____/____/____

Job title.....

One copy of this form must be retained in the Health Record
- another copy has / has not been accepted by the patient.



North East Wales NHS Trust

Extracorporeal Shockwave Lithotripsy
ESWL Consent Form

Surname	
First name	
NHS/hospital no.	
Date of birth	___/___/___

Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, 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 agree that any tissue removed and the results of diagnostic tests may be used for teaching, audit and research that could benefit other patients.
- 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.

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.....
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.....

Signature.....Name (PRINT).....Date ___/___/___

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.....Name (PRINT).....Date ___/___/___

Important Notes: (tick if applicable)

- See also advance directive/living will
- Patient has withdrawn consent (ask patient to sign /date here)

Signature.....Name (PRINT).....Date ___/___/___

One copy of this form must be retained in the Health Record
- another copy has / has not been accepted by the patient.