North East Wales NHS Trust

Surname	
First name	
NHS/hospital no.	
Date of birth	_____/_____/_______

Ureteroscopic Stone Removal 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)	Ureteroscopic Stone Removal. Side __________ Telescopic removal / fragmentation of stone in the ureter or kidney with placement of a soft plastic tube or stent between the kidney and the bladder. This procedure includes cystoscopy and radiological imaging.
Other procedures/treatment which may become necessary during the procedure:	To deal with complications if they occur
Anaesthetic: ❒General ❒Spinal ❒ 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 remove a stone form the ureter or kidney

Risks:

Common

- Mild burning or bleeding on passing urine for short period after operation
- Temporary insertion of a bladder catheter
- Insertion of stent with further procedure to remove it

Occasional

- Kidney damage or infection needing further treatment
- Failure to pass telescope if ureter is narrow
- Recurrence of stones
- Inability to get stone or movement of stone back into kidney where it is not retrievable

Rare

- Damage to ureter with need for open operation or tube placed into kidney from back to allow any leak to heal
- Very rarely, scarring or stricture of ureter requiring further procedures

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:

- Open surgery. Shock wave therapy 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

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Ureteroscopic Stone Removal Consent Form

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.
  …………………………………………………………………………………………………
  …………………………………………………………………………………………………
  …………………………………………………………………………………………………
  …………………………………………………………………………………………………

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.