Patient information and consent to total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x-rays or test results.

- Laxatives and painkillers may be required after your hospital stay; please ensure you have appropriate supplies at home.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

- Please call the gynaecology specialist nurse for your consultant if you have any questions or concerns about this procedure or your appointment.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health.
However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

**About total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy**

- Laparoscopic surgery has been recommended as part of the technique for hysterectomy (removal of your uterus/womb). The indication/reason for the hysterectomy is ................................................................. (Please complete).

The aim is to use keyhole surgery (aided by the laparoscope/telescope) to remove the uterus, cervix, fallopian tubes and possibly the ovaries and cut the supports, and then conventional vaginal surgery to remove the tissues from the body.

A laparoscopic assisted vaginal hysterectomy is where some of the procedure is performed using the telescope and instruments from above, and some of the operation is performed through the vagina. In contrast a total laparoscopic hysterectomy is where all the operating is performed using the telescope and instruments from above and the womb is removed vaginally. Both operations are similar, however your surgeon will discuss which procedure is most suitable for you.

**Intended benefits**

- Total laparoscopic hysterectomy / laparoscopic assisted vaginal hysterectomy with bilateral salpingoophorectomy: We aim to remove the uterus (womb) ovaries, fallopian tubes and cervix for treatment of your condition as discussed in clinic.
- With ovarian conservation: We aim to remove the uterus (womb), cervix and fallopian tubes conserving the ovaries for treatment of your condition as discussed in clinic.

**Who will perform my procedure?**

This procedure will be performed by a consultant gynaecologist or trainee (working under supervision).

**Before your procedure**

A decision will be made with you in clinic about this operation. This will be offered by a consultant or one of the trainee doctors under supervision. You will then be seen at the pre-admission outpatient clinic by the preadmission sisters. The pre-admission assessment may be carried out by phone.
We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

If you are taking any tablets or other forms of medication, you should tell the doctor treating you. Usually, we will ask you to stop hormone-replacement treatment (HRT) or tamoxifen at approximately two weeks prior to surgery, if appropriate.

You will be asked whether you have any allergies. It is important that you tell us about any bad reactions that you have had with medication or operations prior to surgery.

This procedure involves the use of general anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

Most people who have this type of procedure will need to stay in hospital for one to two days after this type of surgery. Usually, you will be admitted on the day of surgery and most women are perfectly fit to be discharged the day following surgery. Please plan for this length of stay (one night in hospital). Your doctor will discuss the length of stay with you.

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read.

**During the procedure**

- Before your procedure, you will be given the necessary anaesthetic - see below for details of this.
- There will be three incisions (cuts) made that you can see. The first is for the telescope and is within or close to the navel (belly button). This is approximately 1 cm long. Two further cuts will be made in the lower half of your abdomen (tummy), which are approximately 5 mm long. An additional cut is made at the top of the vagina to remove the loosened tissue, including the specimen for analysis.
Sometimes additional cuts (ports) are made to aid the surgery.

- A catheter (tube) will be placed in your bladder during the operation to allow accurate measurement of the urine that you produce during and/or after the surgery. This might be taken out immediately after the operation or left until later, for example, when you are less sleepy.
- Small dissolvable stitches are used to close the small skin wounds at the end of the operation. These sutures usually do not need to be removed. If there is problem with the wound please do not hesitate in contacting the ward or your practice nurse for advice and review if necessary.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure, oxygen levels and check for vaginal bleeding regularly too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

Eating and drinking. Usually following surgery you will be able to drink fluids when you are ready. If you feel hungry, you can usually have something light to eat soon after the operation.

Getting about after the procedure. We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital. Generally most people who have had this operation will be able to leave hospital after at least one night, although the actual time you are inpatient can range from eight hours to several days after the operation. If you have problems with the operation or require further treatment you might need to stay in for longer. However, the actual time that you stay in hospital will depend on your general health, how quickly you are recovering from the procedure and your doctor's opinion.

Resuming normal activities including work. You can usually resume normal activities including beginning gentle work within a fortnight after your operation. Often you will want to wait a little longer before resuming more vigorous activity.
Driving will be fine about two weeks after the surgery if you feel comfortable in the driving seat wearing your seat belt.

**Special measures after the procedure:**

- **Vaginal bleeding:** You may have some vaginal bleeding for one to two weeks following the procedure; we advise you to use sanitary towels and not tampons, and to avoid sexual intercourse or swimming until the bleeding has stopped. This is to help prevent any infection. The bleeding may be like a heavy period for the first day or so but this will lessen over time and you may even have a brown discharge before it stops completely. We also suggest that you avoid long soaks in the bath and use a shower instead, and ensure someone is around when you do this in case the hot water makes you feel faint/dizzy. Should you have concerns that your bleeding is not settling or you have a fever and ‘flu-like’ symptoms then contact your GP (General Practitioner) or contact us on the numbers below.

- **Wound care:** The nurses looking after you will have removed any dressing you have covering your wounds before you are discharged and given you some basic advice. You are advised to keep your wounds clean and dry, using a clean towel to pat it dry following your shower. This is especially important for the wound in your umbilicus (tummy button). If you do bath we again emphasise that you are not to have a long soak as this may cause possible infection. If the area around your wounds becomes red, hot to touch or more painful than before, this may be an indication of infection and we suggest you see your GP or contact the emergency gynaecology unit (Daphne Ward) on the numbers listed below.

- **Pain:** You may have period-like pains for a few days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this. Sometimes following a hysterectomy women can have ‘wind’ pain which is painful both in the abdomen and the shoulders. We recommend you drink peppermint tea and some carbonated drinks in addition to your other pain relief as these can help relieve this problem.

- **Bowels:** We recommend you drink plenty of fluids and eat lots of fresh fruit and vegetables to ensure you do not become constipated following the surgery. If your procedure has been performed by the urogynaecology team you will have been discharged with a laxative that we recommend you take as directed.

- **HRT:** For some conditions, if you have had your ovaries removed, you may have been given some Hormone Replacement Therapy (HRT) to help ease the menopausal consequences of the surgery. This should be taken as previously directed. You will need to make an appointment with your GP to discuss the continuation of this.

- **Sexual Intercourse:** We recommend you wait for four to six weeks before you have any penetrative sexual intercourse; this is to ensure you have healed internally. If may find your vagina is drier than before the surgery and you may
find the use of a vaginal lubricant beneficial; this can be purchased from most supermarkets or pharmacies.

Check-ups and results: You will be given information about the results of your surgery after the operation. Usually a letter will be sent with the results as soon as these are available. The follow-up is tailored to your requirements, and a clinic appointment will be sent if appropriate. A clinic visit is not usually booked for routine follow-up after surgery. However, should you feel the need to talk to the surgeons or other staff, please do not hesitate in contacting them.

Significant, unavoidable or frequently occurring risks of this procedure

If you have a pre-existing medical condition, are obese, have significant pathology or have had previous surgery the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of procedure (based on the RCOG Clinical Governance Advice, Presenting Information on Risk). This is further explained in the following patient information leaflet available from the RCOG: Understanding how risk is discussed in healthcare. Information for you.

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent numerical ratio</th>
<th>Colloquial equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common</td>
<td>1/1 to 1/10</td>
<td>A person in family</td>
</tr>
<tr>
<td>Common</td>
<td>1/10 to 1/100</td>
<td>A person in street</td>
</tr>
<tr>
<td>Uncommon</td>
<td>1/100 to 1/1000</td>
<td>A person in village</td>
</tr>
<tr>
<td>Rare</td>
<td>1/1000 to 1/10 000</td>
<td>A person in small town</td>
</tr>
<tr>
<td>Very rare</td>
<td>Less than 1/10 000</td>
<td>A person in large town</td>
</tr>
</tbody>
</table>

Serious risks

- Failure to complete the surgery using the key-hole procedure. This might result in you needing an ‘open’ procedure, in which a larger incision (cut) is made in the abdomen. In a woman without any other medical or surgical problems, the risk of this occurring is 3 in 100 women - uncommon (this includes equipment failure).
- Damage during the surgery to the bowel or to the urinary tract (including the bladder or ureters)
- Haemorrhage (bleeding) during or after the surgery
- Thrombosis (including pulmonary embolus)
- There is a tiny risk of death. You will be cared for by a skilled team of doctors, nurses and other health care workers who are involved in this type of surgery on a daily basis. Any problems that arise can be rapidly assessed and appropriate action taken.
Patient Information

Frequent risks

- Infection (including of the chest, wound, line, bladder, blood)
- Problems at the wound openings/scars (including hernia).

NB: From the literature, it appears that laparoscopic approaches to hysterectomy are associated with less complications, shorter hospital stay and quicker return to normal activity than conventional open operations.

When to seek help

As with any procedure, complications can occur.

You should attend the emergency department immediately for:
- Painful, red, swollen, hot leg, or difficulty bearing weight on your legs
- Shortness of breath, chest pain or coughing up blood

Abdominal pain that is not relieved with the recommended painkillers and is becoming more severe

Alternative procedures that are available

- You should feel happy that at your clinic visit, other options including no surgery were discussed.
- Medical and other treatments will have been discussed with you if appropriate. If not, please ask for further information.

Information and support

You might be given some additional patient information before or after the procedure for examples leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff.

- **Clinic 24**
  Emergency Gynaecology Unit / EPU
  01223 217636
  08:00 – 20:30 Monday to Friday
  08:30 – 14:00 Weekends
  Closed bank holidays

- **Daphne ward**
  Inpatient gynaecology ward
  01223 257206
  All other times reproductive medicine specialist nurse: via switchboard
  Urogynaecology specialist nurse: bleep 157 952
  Gynaecological oncology specialist nurses: 01223 586892

Laparoscopic assisted vaginal hysterectomy, CF234, V9, August 2019
Further information
Additional information is available from the following organisation

Royal College of Obstetricians and Gynaecologists
www.rcog.org.uk

Anaesthesia
Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

**Before your operation**
Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medications**
You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. **Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.**

**Moving to the operating room or theatre**
You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**
Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**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. Your anaesthetist achieves this by giving you a combination of drugs.

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 at the correct level of unconsciousness for the period of the surgery. 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.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinalis, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

**Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember
nothing. Sedation may be used by other professionals as well as anaesthetists.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

Uncommon side effects and complications (1 in 1000 people)

Chest infection
Muscle pains
Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)
Patient Information

Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications
Damage to the eyes
Heart attack or stroke
Serious allergy to drugs
Nerve damage
Death
Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: www.rcoa.ac.uk

Information about important questions on the consent form

1 Creutzfeldt Jakob Disease (‘CJD’)
We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings
As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training
Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.
4 Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.

Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 256998, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.information@addenbrookes.nhs.uk.

Document history

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Version number/Ref 9/CF0234/Document id 1827
Total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

A Patient’s side  left / right or N/A

Consultant or other health professional responsible for your care

Name and job title: 

Any special needs of the patient (e.g. help with communication)?

Please use ‘Procedure completed’ stamp here on completion:

B Statement of health professional (details of treatment, risks and benefits)

1 I confirm I am 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:

a) the intended benefits of the procedure (please state)
   - Total laparoscopic hysterectomy / laparoscopic assisted vaginal hysterectomy with bilateral salpingoophorectomy: We aim to remove the uterus (womb) ovaries, fallopian tubes and cervix for treatment of your condition as discussed in clinic.
   - With ovarian conservation: We aim to remove the uterus (womb), cervix and fallopian tubes conserving the ovaries for treatment of your condition as discussed in clinic.

b) the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient
   - Serious risks: Failure to complete the surgery using the key-hole procedure. This might result in you needing an 'open' procedure / Damage during the surgery to the bowel or to the urinary tract (including the bladder or ureters) / Haemorrhage (bleeding) during or after the surgery / Thrombosis (including pulmonary embolus) / There is a tiny risk of death.
   - Frequent risks: Infection (including of the chest, wound, line, bladder, blood) / Problems at the wound openings/scars (including hernia).

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

d) any extra procedures that might become necessary during the procedure such as:

- Blood transfusion
- Other procedure (please state)

2 The following information leaflet has been provided:

Total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

Version, reference and date: CF234 Version 9 August 2019

or [ ] I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:

- General and/or regional anaesthesia
- Local anaesthesia
- Sedation
- None

Signed (Health professional): _____________________________ Date: 9/08/2019

Name (PRINT): _____________________________ Time (24hr): _____:_____:_____

Designation: __________________________________________ Contact/bleep no: _____________________________

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

- Yes [ ] No [ ]

2 Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

   - Yes [ ] No [ ]

   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

   - Yes [ ] No [ ]

3 Students in training
   I agree to the involvement of medical and other students as part of their formal training.

   - Yes [ ] No [ ]
Consent Form

Total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

4 Use of Tissue
a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research. □ Yes □ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records. □ Yes □ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .................................................. Date: __/__/____
Name of patient (PRINT): ..................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: .......................................................... Date: __/__/____
Relationship to patient: ........................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .................................................. Date: __/__/____
Name of witness (PRINT): ........................................
Address: .............................................................
Consent Form

Total laparoscopic or laparoscopic assisted vaginal hysterectomy and bilateral salpingectomy with ovarian conservation or bilateral oophorectomy

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.
Name (PRINT): .................................................................................. Job title: ..........................................................

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

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

Signed (Interpreter): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.
Name (PRINT): ..........................................................

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.

Signed (Health professional): .......................................................... Date: …D.D./M.M./Y.Y.Y.Y.
Name (PRINT): .......................................................... Job title: ..........................................................