Patient information and consent to transanal endoscopic microsurgery (TEMS)

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 bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies) and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- 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 colorectal specialist nurses during working hours on 01223 217923 if you have any questions or concerns about this procedure. There is an answerphone out of hours so please leave a message and we will return your call.

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

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.

Transanal endoscopic microsurgery (TEMS), CF0397, V4, February 2015
About transanal endoscopic microsurgery (TEMS)

Transanal endoscopic microsurgery (TEMS) is a minimally invasive technique for the local resection of rectal polyps and tumours. The procedure is carried out using a special microscope to remove the polyp or tumour through the back passage without any cuts in the abdomen. It requires a general anaesthetic. Here, we explain some of the aims, benefits, risks and alternatives to TEMS.

We have offered you transanal endoscopic microsurgery to remove a polyp or tumour from your back passage under one of the following circumstances:

- it is not known yet whether the lesion is a cancer or benign (showing no signs of cancer). TEMS allows the lesion to be analysed under the microscope for diagnostic purposes.
- there is a cancer in the back passage that is thought to be an early cancer and potentially could be cured by removing just the cancer without major abdominal surgery
- there is a polyp or cancer in the back passage which is causing symptoms and you have been advised to avoid a major operation either because of anaesthetic risks, to avoid a stoma (where the bowel is brought out through the abdominal wall and the bowel motion comes out into a bag), or due to spread from the cancer
- there is a defect in the back passage which requires repair for example, a fistula.

Transanal endoscopic microsurgery (TEMS) resection is considered as a treatment for early rectal cancer based on the results of clinical examination, colonoscopy, transrectal ultrasound, magnetic resonance scans (MRI) and discussion at the multidisciplinary team meeting. It is only offered in selected cases and is not appropriate for all tumours. It is also important to be aware that TEMS will sometimes simply provide a ‘big biopsy’ and that analysis under the microscope may reveal features of a tumour that would not make it suitable for TEMS surgery alone. If this is the case, you may be advised to still have major conventional resectional surgery to remove the entire back passage as described above.

TEMS is performed transanally (through the back passage) with specially designed microsurgical instruments that makes it possible to excise lesions inside the rectum that otherwise would be accessible only by major abdominal surgery.

The TEMS procedure can only be performed under general anaesthetic. It also normally involves a caudal block which is placed after the anaesthetic has started. This involves an injection in the lower spine to relax the sphincter muscles (bowel control mechanism) during the operation and reduce the chance of injury to the sphincter muscles from the introduction of the operating microscope into the back passage. Anaesthesia is discussed in more detail at the end of this document/form.
Intended benefits

The potential benefits of TEMS as compared to radical abdominal surgery are:
- avoiding major surgery
- no large incision
- no colostomy
- less pain
- faster recovery
- shorter hospital stay.

TEMS may also provide a definitive answer as to whether a polyp is benign (non-cancerous) or malignant (cancerous), or be curative for some tumours.

Who will perform my procedure?

TEMS is a specialist procedure that will only be performed by a consultant colorectal surgeon or specialist registrar in colorectal surgery under appropriate supervision.

Before your procedure

Most patients attend a pre-admission clinic, when you will meet a member of the medical team. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

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.

This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia 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 or two nights after the operation. Sometimes we can predict whether you will need to stay for longer than usual - your doctor will discuss this with you before you decide to have the procedure.

On the day of the procedure, you will be asked not to eat for six hours before the surgery and to only drink clear fluids between six hours and two hours prior to the surgery. Nothing is allowed by mouth after two hours before surgery apart from normal medications with a sip of water.

You will be given two enemas to clear the lower bowel prior to the operation in order to allow visualisation of the tumour with the operating microscope.
Hair removal before an operation
For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

During the procedure
Before your procedure, you will be given a general anaesthetic and may be advised to have a ‘caudal block’ to relax the sphincter (anal muscles) as well - see below for details of this.

During the procedure, you will be positioned on the operating table to allow insertion of the operating microscope into the back passage. The back passage is inflated with carbon dioxide and the tumour is removed using specially designed instruments, with the surgeon looking down the operating microscope. Once the tumour/polyp is removed, the back passage is washed out, any bleeding is stopped and the defect in the wall of the back passage may be closed with stitches.

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.

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 and oxygen levels 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.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.
After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

**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.** After this procedure, you will be allowed to eat or drink as soon as you feel able to do so (usually within an hour of surgery).

**Getting about after the procedure.** We will encourage you to try and get up and about as soon as possible. This helps improve your recovery and reduces the risk of certain complications. Typically, you will be able to get up after a couple of hours. If we think you will have problems getting about, we will arrange for extra assistance, for example, nursing help and physiotherapy advice/exercises.

**Leaving hospital.** Most people who have had this type of procedure will be able to leave hospital after one or two nights. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion.

**Resuming normal activities including work.** Most people who have had this procedure can resume normal activities after a couple of days. You might need to wait a little longer before resuming more vigorous activity. When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. Please ask your doctor for his/her opinion.

**Special measures after the procedure.** The effects of the caudal block may take up to a few hours to wear off. During this time you may find that your legs feel heavy and do not work properly, or that you are unable to pass urine. All should resolve within four to six hours.

It is important to keep your bowels regular after TEMS, using laxatives such as Milpar if necessary. You will be given more detailed information about any special measures you need to take after the procedure. You will also be given information about things to watch out for that might be early signs of problems (for example, infection). It is common to experience a little blood from the back passage after your operation; if this is severe, you will need to
Check-ups and results: before you leave hospital, we will give you details of when you can expect to receive telephone communication of results or when you need to return to see us, for example, in the outpatient clinics or for further tests. At this time, we can check your progress and discuss with you any further treatment we recommend.

Significant, unavoidable or frequently occurring risks of this procedure

Although TEMS is a minimally invasive technique with lower risks than abdominal surgery, it still carries some risks associated with the technique. The risks or potential post-operative complications that may occur after TEMS are listed below:

- bleeding may occur during the operation. After surgery, some bleeding will usually be noticed on having the bowels open. There is a one in a 100 risk of significant postoperative bleeding (haemorrhage) although this usually stops of its own accord. If not, it can be controlled with a colonoscope or repeat TEMS. A blood transfusion may occasionally be required if this happens.
- the performance of the anal sphincter muscle can be affected after TEMS, although this effect is almost always temporary. If this happens, you may find that you have difficulty controlling gas for about two to three months after surgery. Very occasionally, incontinence to liquid or solid stool occurs. Again, this is almost always temporary. The risk of long-term bowel incontinence is very low.
- emptying of the bladder (urination) may be temporarily impaired due to the type of anaesthetic used and pressure from the operating microscope. This usually resolves within a few hours or days at most. It may sometimes be necessary to temporarily insert a catheter into the bladder to drain the urine if this occurs.
- if you suffer from urinary symptoms due to a large prostate you might be at increased risk of urinary problems after surgery.
- removal of the tumour involves removal of the wall of the back passage. There is a one in 50 risk of infection of the TEMS wound that may give rise to fever or infection in the tissues surrounding the back passage. Most cases can be treated with antibiotics. Sometimes it is necessary to drain infection with a drain inserted under X-ray guidance or with surgery. A temporary stoma is very occasionally required to aid the healing process. Very rarely, the infection may cause generalised blood-poisoning and intensive care may be necessary.
- operating on tumours situated high up the rectum can lead to an entry being made into the abdominal cavity. The opening is usually sealed during the operation with stitches placed through the operating microscope. However, there is about a one in 100 risk of the need to repair the defect through the abdomen (this is called a laparotomy) or may be performed using keyhole surgery (laparoscopy). If these stitches later break down or leak, then it is possible for bacteria from the back passage to enter the abdominal cavity and cause infection, either an abscess
(collection of pus) or peritonitis (infection in the abdominal cavity). This risk is about one in a 1000.

- neighbouring organs can be damaged during an operation. A fistula (connection) towards the vagina in women or towards the urethra (tube connecting the bladder to the tip of the penis) in men can rarely occur, which will require further surgery to repair. This risk is about one in a 1000.
- the body must be situated in a particular position on the operating table. This can sometimes lead to problems such as numbness or odd sensations in the legs. This is temporary, but sometimes full recovery can take months.
- scarring may occur after a TEMS operation, and this may cause narrowing of the bowel (stenosis). In most cases, a stenosis can be widened through the back passage.
- risks associated with all operations include blood clots, pneumonias, heart problems and kidney problems. The risks associated with TEMS are relatively low as the procedure does not involve any cuts or a prolonged recovery time.
- there is a chance that you may be advised to undergo a further operation or other treatment, for example radiotherapy once the tumour or polyp has been analysed in the laboratory.

**Alternative procedures that are available**

If it is not yet known whether a polyp is cancerous or not, it is sometimes possible to try and remove the polyp during a colonoscopy. However this frequently involves the polyp being removed in several pieces, rather than one specimen. This may therefore make interpretation of the polyp in the laboratory more difficult, for example, as to whether the polyp has been adequately removed or not.

Some tumours low in the back passage can be removed under direct vision. This procedure is known as transanal resection of tumour (TART). It can only be used for very low tumours and the cancer outcomes are not as good as they are with TEMS. It may however be the right procedure for a polyp that is prolapsing (dropping out) of the back passage.

Some people prefer not to have any treatment at all. The implications of deciding not to have surgery will be discussed with you.

The standard treatment for rectal cancer usually involves surgical resection of the entire back passage and its fatty covering with lymph nodes (this is known as ‘total mesorectal excision’). The bowel is then joined back together again if there is enough distance below the cancer (‘anterior resection’). If there is not enough distance below the cancer, this will result in closure of the back passage and a permanent stoma (‘abdominoperineal excision of rectum’). Treatment often includes additional radiotherapy and/or chemotherapy.
Information and support

We may give you some additional patient information before or after the procedure, for example, leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please ask a member of staff.

If you have concerns or questions after leaving hospital, then please contact the colorectal specialist nurses during working hours on 01223 217923, or leave a message on the answerphone after hours.

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-medication

You may be prescribed a ‘premed’ prior to your operation. This 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, 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 and you may be asked to breathe oxygen through a face mask.

**Before starting your anaesthesia the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

**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.

**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 general 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
Patient Information

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)

**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](http://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 now 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, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk.

Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

Document history

Authors: Colorectal Surgery
Department: Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
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A Patient's side N/A

Consultant or other responsible health professional

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)
   - avoiding major surgery
   - no large incision
   - no colostomy
   - less pain
   - faster recovery
   - shorter hospital stay. Any other (please specify):

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.
   Full details of the risks are set out in the patient information and include:
   - bleeding;
   - urinary problems especially if the patient suffers from a large prostate
   - affecting the performance of the anal sphincter muscle
   - temporary impairment when emptying the bladder
   - 1 in 50 risk of infection of the TEMS wound, possibly leading to infection/fever
   - 1 in 100 risk of laparotomy or laparoscopy
   - rare (1 in 1000) risk of damage to neighbouring organs
   - scarring may occur after a TEMS operation and may cause stenosis
   - general risks associated with all operations (blood clots, pneumonias, heart/kidney)

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:
Transanal endoscopic microsurgery (TEMS)

2 The following information leaflet has been provided:

Transanal endoscopic microsurgery (TEMS)

Version, reference and date: CF0397, version 4, February 2015

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: __/__/2015

Name (PRINT): __________________________ Time (24hr): __:__

Designation: __________________________ Contact/bleep no: __________________________

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
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.

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.

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: ___________________________
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:

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:

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: .................................................................