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 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.

- 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 attend Preassessment before this procedure and bring your results with you on the day of your admission if requested.

- For any concerns requiring urgent medical advice please contact the nurse specialist during working hours on 01223 596383 or through the hospital contact centre on 01223 245151 and ask for pager 154-348 or extension 6383. In the evenings or at weekends please contact ward C7 or M4 via switchboard.

- **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.

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.
What is gastro-oesophageal reflux disease?

Gastro-oesophageal reflux disease (GORD) occurs when the acidic contents of the stomach flow backwards into the oesophagus causing inflammation of the lower oesophagus (oesophagitis). This may lead to a number of symptoms including heartburn, regurgitation of semi-digested food, difficulty swallowing and pain on swallowing. In addition, you may also experience welling up of a foul tasting fluid into the back of your mouth; you might also notice fluid welling up when you bend over to tie your shoes or to lift something up. Rarely, GORD may be associated with chest conditions such as asthma and may also lead to problems with tooth decay.

GORD occurs when there is a failure of the valve (sphincter) at the lower end of your oesophagus (gullet). This valve should prevent fluid from the stomach passing back up your oesophagus, but in patients with GORD this is not the case and fluid from the stomach can pass freely into the oesophagus. Although not the cause, patients with GORD frequently also have a hiatus hernia. This occurs when the upper part of the stomach and valve in the lower part of the oesophagus sit in the chest cavity, rather than the abdominal cavity.

What are the options for treating gastro-oesophageal reflux?

The majority of patients who have gastro-oesophageal reflux treat their condition with simple over the counter medicines, (for example, Rennies), that reduce the acidity in the stomach.

If these simple measures do not work then patients are commonly prescribed tablets that reduce the acid levels in the stomach. These drugs are collectively known as proton pump inhibitors (‘PPI’, for example, Lansoprazole, Omeprazole, Esomeprazole, Pantoprazole and Rabeprazole). These drugs are highly effective at relieving the symptoms of gastro-oesophageal reflux; they do not do anything to the sphincter at the lower end of the oesophagus.

Sometimes patients notice an improvement in their symptoms if they lose weight or give up alcohol and smoking. We therefore generally advise people, who have severe reflux disease, to follow these measures and also to avoid eating large meals late at night and drinking high volumes of drinks containing caffeine.

What is the aim of surgery?

Surgical operations for reflux disease aim to prevent acid reflux by reinforcing the valve mechanism at the lower end of the oesophagus so that the fluid cannot reflux into the oesophagus from the stomach. The sphincter mechanism itself cannot be directly repaired. Instead it is reinforced by buttressing the valve mechanism with the upper stomach.

Surgical treatment for acid reflux disease has been around for many years but has become more popular in recent times as keyhole methods (laparoscopic) for carrying out the surgery have been developed and it is also related to the increased number of patients who suffer with GORD.

Laparoscopic anti-reflux surgery, CF147, v6, October 2016
**Who is suitable for surgery?**

Surgery can potentially benefit the majority of patients who have troublesome acid reflux disease. However, it is important that you are fully aware of the different options for treating your reflux disease before having an operation.

It is critical that a precise diagnosis of gastro-oesophageal reflux disease is made prior to surgery. It is most important to be certain that reflux is causing your symptoms. There are many other conditions of the oesophagus and stomach that can cause symptoms which may be interpreted as reflux. These other conditions are not helped by surgery and may be made worse. Therefore, your surgeon will carefully help you to decide whether surgery is likely to help your symptoms.

The majority of patients who wish to explore the possibility of surgical treatment are those who have severe reflux symptoms that are inadequately relieved by taking medication. Some patients would prefer not to stay on long-term medication, or have had side effects from the PPI medications they have been prescribed.

**What tests do I need before the operation?**

Before you have a surgical treatment for your gastro-oesophageal reflux, it is important that we confirm that this is the problem as other conditions can mimic GORD and they would not be helped by this type of surgery. You will undergo an endoscopy test to have a look to see if you have oesophagitis, (inflammation of your gullet), or a hiatus hernia.

You will also be asked to undergo some tests of your oesophagus to make sure that the muscles within the oesophagus work properly and strongly when you swallow. You will also be asked to undergo a test where a fine catheter tube is placed down your nose for a 24 hour period; this catheter tube measures the acid (pH level) in your lower oesophagus and allows us to confirm that you have an abnormal degree of acid reflux.

We will also ask you about your response to acid reducing medications, as frequently patients who respond well to these medications do well after surgery.

**Who makes the final decision regarding surgery?**

When we have all the information available from your pre-operative tests we will discuss with you the benefits and disadvantages of surgery. If we feel you will benefit from the surgery, it will still be your final decision as to whether you wish to go ahead with surgery.

**Intended benefits**

Following surgery you should stop taking your antacid medications and you will notice an improvement of acid reflux symptoms. Long term side effects of antacid medications will be decreased.
Who will perform my procedure?

Your operation will be performed by a consultant surgeon or by a senior surgeon in training under the direct supervision of the consultant surgeon.

Before your procedure

Most patients attend a pre-admission clinic, when you will meet a member of the surgical 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 any packaging with you.

This procedure involves the use of 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.

We will ask if you are allergic to anything and for details of any of your previous operations.

A member of the surgical team will discuss any issues you have and you will be given a consent form to take away with you at this time and to bring back to hospital when you are admitted.

Usually you will be admitted to hospital on the morning of your operation. We will advise you what you can eat and drink before the operation, and when you must stop eating or drinking before the operation.

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 operation

Before your operation you will be taken to the operating theatre and the anaesthetist will insert a plastic tube (drip) in your hand or arm through which you will be given an injection which will make you sleepy.

During the operation the anaesthetist will stay with you at all times and you are closely monitored. Monitoring machines will measure your heart rate, blood pressure and oxygen levels within your blood.

While you are asleep a fine tube may be passed through your nose into your stomach to drain the air off the stomach; this will be removed at the end of the procedure.

We perform this type of surgery using a keyhole (laparoscopic) approach. This allows us to use long thin instruments and cameras to work inside your abdomen, using small incisions rather than through a traditional large incision.

There is always a small chance (5%) that a larger incision will be made on the abdomen. This is done if the operation is unable to be completed using the key hole technique or if there is a complication such as bleeding that cannot be controlled using a key hole technique.

This approach means that you experience much less pain after the operation and thus, able to recover more quickly.

When the special keyhole (laparoscopic) instruments have been inserted the liver is lifted out of the way with a special instrument allowing us to identify the lower oesophagus and stomach, where we will do the actual operation. This area is freed up preserving the nerves that lie around this area that control your intestine. The upper part of the stomach (fundus) is then freed from its attachments. This involves dividing some small blood vessels that run between the fundus and the spleen.

Once the fundus of the stomach and the oesophagus are completely mobile the stomach is manipulated around the back of the oesophagus and stitched to prevent acid reflux. If you have had a hiatus hernia the diaphragm through which the hernia was extending will also be repaired using some stitches.

The incisions will be closed with dissolving sutures and injected with local anaesthetic so that you are comfortable when you wake up.

Your wounds will be closed with waterproof dressings or glue, which means that you can shower. We ask you to remove the dressings yourself at home five days after the operation and if you had glue applied to the wound you do not need to remove anything.
After the operation

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.

It is very important that you are not sick and you will be given a number of anti-sickness medications while you are asleep. If, after the operation you feel at all sick, you must immediately inform the nurses looking after you.

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.

The operation aims to increase the pressure of the valve mechanism at the lower end of your oesophagus.

You will, therefore, notice that in the first few weeks after your operation it is more difficult to swallow food than it was before your operation. This is entirely normal and advice is given below as to the type of food you should eat during this period.

You need to be very careful about eating foods of a coarser texture, such as bread or red meat. If these are eaten too quickly or too large a mouthful is swallowed they may become stuck in the lower end of the oesophagus.

Because the valve has been tightened it is difficult for patients to belch and this can lead to painful trapped wind. In a similar manner, it is also difficult for patients to be sick. All these symptoms do improve with time, but it is important that you avoid precipitating these symptoms as much as possible in the early post-operative period.

Approximately 50% of the patients who have this operation notice that they pass more wind through their bottom after the operation. Simple medications that absorb gas can be obtained over the counter at a chemist.

Eating and drinking. After your operation, (on the same day), you will be allowed to drink water and then progress onto other fluids during the day as you feel able and provided you do not feel sick. You will be monitored carefully and given regular painkillers and anti-sickness medications to prevent sickness occurring.

The day after your operation, you will be seen by the surgical team and provided you are well you will be allowed to start eating soups and simple soft food.

We advise you during this period to avoid liquids that are either particularly hot or cold, but generally take tepid fluids. We would also caution against taking fizzy drinks.
Patient Information

After the procedure we advise:

- eating food that is soft, sloppy and easy to swallow. This means avoiding foods that contain large pieces (for example, bread or red meat)
- always take your time eating and chew your food very well
- if you are having difficulties swallowing initially, we advise you to only take foods of a consistency that you can suck up with a straw. After about two weeks you should be able to increase this to sloppy foods such as mashed or vitamised foods for another two weeks
- suitable foods such as soups, pasta, mashed vegetables and mince avoiding fizzy or gassy drinks that might make you feel bloated. This is because you are generally less able to belch or burp due to the surgery.

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. On discharge, we will give you a copy of your discharge summary. We would expect to discharge you one to two days after your operation.

Resuming normal activities including work. After your operation we would expect you to make a quick recovery from your surgery. You are able to resume normal activities as you feel comfortable. In general, you can resume driving a week or so after your operation. We would advise against extreme physical activity (weight lifting or heavy lifting), for about a month after the operation so that all the swelling and post-operative effects have settled down.

Special measures after the procedure: Kindly adhere to the post operative diet information that will be given to you on discharge.

Check-ups and results: You will be seen in the surgical clinic six weeks after your operation to assess your progress. During the first six weeks after your operation we would expect you to experience some difficulty with your swallowing and will advise you regarding the diet you should stick to. In general, you should avoid eating chunky food (for example, pieces of meat) and dry foods (for example, bread) for the first six weeks after your operation.

We believe that it is important that we monitor the effects of your operation over a long period of time to ensure that the good results of the surgery are maintained. We will see you in outpatients in early post-operative period but after this will continue to follow-up with a telephone questionnaire. The details of this will be discussed with you while you are in hospital.

Laparoscopic anti-reflux surgery, CF147, v6, October 2016
Significant, unavoidable or frequently occurring risks of this procedure

Keyhole (laparoscopic) surgery for acid reflux disease is a safe procedure. However, there are potential risks involved in any form of surgery and we believe that it is important that you are aware of these.

Damage to the spleen. During the part of the operation discussed earlier, the small blood vessels between the spleen and the upper part of the stomach (fundus) are cut using special instruments that seal the blood vessels before they are divided. However, sometimes damage to the spleen can occur. Frequently this can be controlled simply using the keyhole method, however, if the spleen were to sustain more severe injury this may require conversion to an open cut operation with the potential of removal of the spleen. This risk is small.

Damage to the oesophagus. When the oesophagus is being freed up inside your abdomen there is a risk that it can be damaged. If this is seen at the time of the operation it can be repaired simply and the operation will be completed using the keyhole method, or it may mean you need to stay in hospital for a slightly longer period of time to ensure that it heals up well.

Severe swallowing difficulty. While we expect you to notice things go down more slowly after your operation, a few patients experience severe problems with swallowing in the first few days after their operation. If this occurs, it may be necessary to perform a second keyhole operation to loosen or remove some of the stitches we have put in.

Wound infection. These are rare with keyhole surgery and if they do occur can be treated simply with antibiotics.

Damage to other organs inside your abdomen. This is a rare complication of keyhole surgery but it has been recognised that during the insertion of instruments into the abdominal cavity damage can occur to any other intra-abdominal organs, including the intestine, liver and blood vessels. If this were to occur then it is likely that the approach to the operation would have to be changed from a keyhole approach to an open approach.

Chest infection. Because you are relatively comfortable and able to easily mobilise after the operation, chest infections are rare. If a chest infection did occur it could be treated with antibiotics. If you are a smoker you should stop smoking at least 6 weeks before surgery to decrease perioperative complications.

Deep vein thrombosis (DVT) and pulmonary embolus - All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. In the worst case a clot in the leg can break off and travel to the lung (pulmonary embolism). This can significantly impair your breathing. To prevent these problems around the time of your operation and following your operation we give you some special injections to ‘thin’ the blood.
We also ask you to wear compression stockings on your legs before and after surgery and also use a special device to massage the calves during the surgery. Moving about as much as you can, including pumping your calf muscles in bed or sitting out of bed as soon as possible reduces the risk of these complications.

**Conversion to an open operation.** We always warn people who are undergoing a keyhole procedure that there is a small risk that if the operation is technically not possible to complete through a keyhole technique we will make an open cut. If this is necessary, it will result in a larger scar and more post-operative discomfort and, inevitably, a longer stay in hospital.

**Scarring** – Any surgical procedure that involves making a skin incision carries a risk of scar formation. A scar is the body’s way of healing and sealing the cut. It is highly variable between different people. All surgical incisions are closed with the utmost care, usually involving several layers of sutures. The sutures are almost always dissolvable and do not have to be removed. The larger an incision the more prominent it will be. Despite our best intentions, there is no guarantee that any incision (even those only 1-2 cm in length) will not cause a scar that is somewhat unsightly or prominent. Scars are usually most prominent in the first few months following surgery, however, tend to fade in colour and become less noticeable after a year or so.

**Requirement for re-operation** – It is unlikely (5%), although possible, that some time after the operation you may need a further procedure. This is because it is possible for things to move slightly inside or for sutures to give way. If this is the case this may need to be corrected with another operation to revise the previous procedure. In very rare cases coughing, heaving or vomiting in the first few days after the operation can cause things to move or a suture to give way. This then may require another operation to correct it.

**Other complications** – We have tried to describe the most common and serious complications that may occur following this surgery. It is not possible to detail every possible complication that may occur following any operation. If another complication that you have not been warned about occurs, we will treat it as required and inform you as best we can at the time. If there is anything that is unclear or risks that you are particularly concerned about, please ask.

**Alternative procedures that are available**

An alternative to this surgery is a decision not to have surgery and continuing medications. We will discuss with you the implications of deciding not to have surgery.

**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 feel free to ask a member of staff including your surgeon or one of the senior trainees.
If you experience any concerns requiring urgent medical advice please contact:

- the nurse specialist (Monday – Friday 09:00-17:00) on 01223 596383 or through the hospital contact centre on 01223 245151 and ask for pager 154-348;
- or extension 6383 ward C7 or M4 (evenings and weekends) via switchboard (01223245151).

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.

Regional Anaesthesia
Regional anaesthesia includes epidurals, spinals, 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.

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 and 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. 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, 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)

**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.
Consent Form

Laparoscopic anti-reflux surgery

A Patient’s side  left / right  or  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)
   To prevent acid reflux

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

   Damage to the spleen, oesophagus and other organs in the abdomen; severe swallowing difficulty; increased flatus, difficulty belching, bloating, wound infection; chest infection; DVT; conversion to open operation

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

Laparoscopic anti-reflux surgery

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:
   Laparoscopic anti-reflux surgery

Version, reference and date: Version 6, CF147, October 2016

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: __/__/YYYY

Name (PRINT): __________________________________________ Date (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

Patient safety – at the heart of all we do
Consent Form

Laparoscopic anti-reflux surgery

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: D.D./M.M./Y.Y.Y.
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: D.D./M.M./Y.Y.Y.
Relationship to patient:

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

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

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