Patient Information

Cambridge University Hospitals
NHS Foundation Trust

Patient Information

Patient information and consent to laparoscopic abdominal wall hernia surgery

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.

- If you experience any concerns requiring urgent medical advice please call the nurse specialist during working hours on 01223 596383 or through the hospital contact centre on 01223 245151 and ask for pager 154-348. During evenings or weekends please call ward C7 on 01223 217300.

- **Important - please bring this form with you to the hospital on the day of your procedure.** 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.
About laparoscopic abdominal wall hernia surgery

Your surgeon has recommended that you undergo an operation for an abdominal wall hernia. These hernias occur at different sites of the abdominal wall. Some of these hernias have specific names such as umbilical, paraumbilical, epigastric, incisional or spigelian. They all have the following in common: the hernia involves a weakness of the muscles and connective tissue of the abdominal wall.

It has been recommended that you have this surgery performed using a keyhole technique. This involves a series of small incisions on the abdominal wall, rather than a single, longer, incision over the site of the hernia.

An abdominal wall hernia is an abnormal protrusion through the abdominal wall. The protrusion contains a small bag of abdominal lining (the hernial sac) which can be empty or it can fill with abdominal contents such as bowel. Typically hernias are more obvious when standing or straining (for example, coughing, heavy lifting, digging) as this forces bowel into the sac. Hernias usually develop over time for no obvious reason, although in some people there may be an inborn weakness in the abdominal wall. Occasionally a strenuous activity will cause a lump to appear suddenly. They may occur at any age and are more common in men than women. Abdominal wall hernias are more common in patients who are overweight.

Hernias may simply present as a painless bulge that enlarges with standing or coughing. Commonly though they cause an aching discomfort or a dragging sensation. Occasionally a piece of bowel or fat can get stuck and twisted within the hernia. This is very painful and can lead to a strangulated hernia which is a life-threatening emergency. It is generally recommended, therefore, that hernias be repaired to prevent such complications arising.

Intended benefits

The intended benefits of this procedure include:

- repair of your hernia
- preventing future complications such as the requirement for emergency surgery if the hernia comes out and gets stuck
- relieving discomfort caused by the hernia
- preventing the hernia from enlarging and causing further symptoms which will also make any future surgery more complex.

Who will perform my procedure?

A suitably qualified and experienced surgeon or a trainee surgeon under the direct supervision of a suitably qualified and experienced surgeon.

Before your procedure

Most patients attend a pre-admission clinic, when you will meet a member of the surgical team, usually a house officer (junior doctor) or a specialist nurse. At this clinic, we will ask for details of your medical history and carry out any necessary Laparoscopic abdominal wall hernia surgery, CF420, v3, August 2015
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.

Hernia surgery can often be performed as a day case procedure under a brief general anaesthetic.

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.

It may be necessary during the procedure to shave other areas of your body if appropriate to allow equipment/machines, for example diathermy machines (used to seal blood vessels), to stick to your skin to achieve the best and safest performance.

During the procedure
At the start of your procedure, you will be given the necessary anaesthetic and/or sedation - see below for details of this.

Several (usually three) small incisions (each 1-2 cm) are made in the abdominal wall skin so that the key hole instruments can be placed within the abdomen. Some patients are surprised that the small incisions are often placed some way away from the hernia itself.

The first step is to dissect out the hernia sac from inside and push its contents back into the abdominal cavity. The hole in the abdominal wall can then be seen. The hole is then strengthened with the aid of an artificial mesh which is laid over the weakness and secured with sutures to prevent the hernia returning. Surgical tacks (like staples) are also used to prevent the mesh from moving.

The mesh used is composed of prolene. It is very similar to the material that sutures are made from. It normally has no adverse effects and incorporates into the body’s own tissues, strengthening them and thereby repairing the hernia. Sutures are placed through, usually four to six, tiny incisions in the abdominal wall skin that are each around 3mm across.
The wounds are then closed with invisible absorbable stitches under the skin. You will not be able to feel the mesh which is deep inside you. It is made of a material (usually primarily prolene) which does not create a reaction from the body and is strong from the moment that you wake up. The dressing is shower-proof and we ask you to keep it on for five days after surgery.

**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.

**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 surgery.**

**Pain Relief:** Local anaesthetic is usually injected into the wound to minimise pain immediately after surgery and this lasts for four to six hours. Sometimes patients can be quite sore for several days following laparoscopic abdominal wall hernia repair. This can be quite surprising because the incisions are small, however, quite an extensive procedure may have been performed inside the abdomen. As the discomfort decreases you will need less pain relief but you might not be fully comfortable for two to four weeks.

**Eating and drinking.** After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe – this is usually within about two hours.

**Getting about after the procedure.** It is safe to perform light duties immediately after the operation, but sensible to avoid heavy work for four to six weeks. However, the only thing to hold you back will be discomfort and, if the wound is not hurting, you can do what ever you like.

**Leaving hospital.** Most people who have this type of procedure under general anaesthetic will be able to leave hospital the same or following day. The actual time you stay in hospital will depend on your general health, how quickly you recover from the procedure, how complex and large the hernia is, how comfortable you are and your doctor’s opinion.
Resuming normal activities including work. You should be able to return to office work after two weeks and manual work after about six weeks.

Driving. You are not insured to drive unless you are confident that you can brake in an emergency and turn to look backwards for reversing without fear of pain in the wound. This will usually be about 10 to 14 days after your operation. If in doubt you should check with your insurers.

Special measures after the procedure.
Wound. There are no stitches to remove. You should shower for the first five days and then you can soak in a bath and peel the plastic dressing off and leave the wound open to the air.

If the wound becomes red, hot or mucky see your GP immediately in case you have a wound infection and need antibiotics. Alternatively you can ring the ward or Day Surgery Unit out of hours. Expect some numbness beneath the scar - this may be temporary or permanent. Bruising around the wound is sometimes seen - this looks dramatic but is harmless and will settle spontaneously.

Check-ups and results. You will normally be given a follow-up in the hospital clinic about six weeks following your operation. Sometimes this is not necessary and you can see your GP for follow up.

Significant, unavoidable or frequently occurring risks of this procedure
Hernia repair is generally a very safe operation with few risks, but rarely complications can occur. Therefore, in the period following your operation you should seek medical advice if you notice any of the following problems:

- increasing pain, redness, swelling or discharge
- severe bleeding
- difficulty in passing urine
- high temperature over 38°C or chills
- nausea or vomiting.

Conversion to an ‘open’ operation - All keyhole procedures carry a small risk of the need to convert the procedure to an ‘open’ technique. This is usually because of some technical difficulty during the procedure. If this is necessary, it may result in a much larger scar, a longer hospital stay and more postoperative pain and discomfort. However, if it is unavoidable, then we must have your permission to proceed to ‘open’ surgery should it be necessary.

Bleeding – This very rarely occurs after any type of operation. Your pulse and blood pressure are closely monitored both after your operation as this is the best way of detecting this potential problem. If bleeding is thought to be happening, you may require a further operation to stop it. This can usually be done through the same
scar(s) as your first operation. It is possible that you may also require a blood transfusion.

**Wound Infection** – The wounds can, rarely, become infected. If you notice redness, discharge or increasing pain from a wound you should consult with your doctor in case you need treatment.

**Wound haematoma** - Bleeding under the skin can produce a firm swelling of blood clot (haematoma), this may only become apparent several days after the surgery. This may simply disappear gradually or leak out through the wound.

**Injury to intestine, bowel and blood vessels** – Injury or damage to these structures can, very rarely, occur during any operation within the abdominal cavity. This is particularly the case if there has been previous surgery with scarring and structures are abnormally stuck to each other. Usually such an injury can be seen and repaired at the time of the operation, but occasionally it may only become clear in the early postoperative period. If we suspect that you may have sustained such an injury, a further operation will be required. This will be performed as a keyhole operation but will need conversion to an open operation if necessary.

**Deep vein thrombosis (DVT) and pulmonary embolus.** All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. Keyhole surgery has a lower risk of this, and we also are able to get patients up and about much quicker after these procedures than after conventional ‘open’ procedures. We do, however, give you some 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.

**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 (almost always the sutures are 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 1 to 2cm 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.

**Seroma** – An accumulation of fluid adjacent to mesh that is used to repair a hernia is called a seroma. This is actually part of the body’s normal healing response. It may actually feel as if the hernia lump is still there! If the hernia is large it is expected that a seroma will develop. Fortunately, in itself, a seroma is not serious and most people do not notice it. It will usually resolve over a period of weeks to months.

If a seroma causes discomfort it may need to be drained under local anaesthetic in the X-ray department or in outpatients. This is where a small drain is placed into the fluid and the fluid is removed.
**Mesh infection** – All artificial materials that are placed into the body carry a risk of becoming infected. This is very rare (estimated 1 in 500 chance). If this were to occur you would notice redness and pain around the hernia site, you may also have a fever and some smelly fluid escaping from the wound. Often this problem can be treated with powerful antibiotics, although a course of four to six weeks may be required. If the infection does not resolve then the mesh may have to be removed with an operation. This would mean that the hernia may eventually come back and several months or years later it may need to be repaired again.

**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**

The principle alternative to the procedure outlined is not to have any surgery to the hernia. In some cases, particularly of very small or very large hernias, the chances of life threatening problems such as strangulation are small. In most other cases no treatment runs the small risk that strangulation might occur and require an urgent operation. The hernia may also increase in size as time goes by.

Hernias can be repaired using a single incision on the abdominal wall, located close to or over the hernia itself rather than using keyhole surgery.

Often, small hernias are in the first instance better repaired using the simpler technique of making a single small incision rather than the several incisions required for key hole surgery.

Each hernia is different and the different options considered for each patient. Neither technique is necessarily “better” than the other.

There are no alternative procedures in the field of complementary medicine that can be used to treat an abdominal wall hernia.

Occasionally, an abdominal wall support or truss can be used to help deal with an abdominal wall hernia.

This is an unusual treatment and we do not supply these devices. These devices are usually only recommended in patients who are not fit enough to undergo surgery.

**Does my hernia need to be repaired?**

Not all hernias need to be repaired. If a hernia is not causing symptoms or enlarging it may not need to be repaired.

Hernias that are not causing symptoms are unlikely to develop serious complications such as strangulation.

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If you have other serious medical problems or are frail, then the risks of repairing the hernia may outweigh the benefits.

Your surgeon will advise you whether he or she recommends surgery. However, you need to make the final decision whether you wish to go ahead with the surgery and this is usually a decision best made in conjunction with your surgeon.

**Will my hernia return?**

There is no method of hernia repair that can give a 100% guarantee that you will never develop another hernia in the same place after your operation. Fortunately, recurrence after hernia surgery should be rare. There are different causes for a hernia coming back. Larger hernias are generally more likely to recur.

Sometimes another hernia can develop on the abdominal wall at a different site. Patients who are obese have a greater risk of recurrence.

**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 or contact one of the consultant surgeons on 01223 217421 or 01223 348024.

**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**

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

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.

**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 general or regional 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
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
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Consent Form

Laparoscopic abdominal wall hernia surgery

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)

To repair your hernia.

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 are set out in the information leaflet and include: wound haematoma; infection; recurrence; vascular or intestinal injury; seroma, open procedure.

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:
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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 abdominal wall hernia surgery

Version, reference and date: Version 3, CF420, August 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: D.D. / M.M. / Y.Y.Y.Y.
Name (PRINT): ........................................................................ Time (24hr): H.H.: M.M.
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
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:  ................................................................................................................................................................
Consent Form

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