Patient information and consent to retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress urinary incontinence

### 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. You will need to starve for six hours before the operation and drink only clear fluids, water is best, for three hours before.

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

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

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

- Simple painkillers such as paracetamol and ibuprofen and laxatives may be required after your surgery. It is suggested that you have a supply of these medications at home to take as you need according to the instructions.

- **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. **Do not** take any medications used to treat diabetes.

- **Please call the urogynaecology specialist nurse on telephone number 01223 245151 and ask for bleep 157 952** if you have any questions or concerns about this procedure or your appointment.

After the procedure we will scan the consent form in your electronic 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 responsible health professional, 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 (2018).

About retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress urinary incontinence

These operations involve inserting a strip of tape made of a synthetic material (polypropylene) to form a sling that supports the urethra (pipe that leads from the bladder to the outside). This helps to stop urine from leaking out.

These are performed under a general anaesthetic in the day surgery unit of the hospital, which is currently based in the Addenbrooke’s Treatment Centre (ATC).

Intended benefits

- The aim of this procedure is to cure or improve stress urinary incontinence. This will not improve symptoms of frequency and urgency.
- No operation is guaranteed to cure stress incontinence but these procedures offer a good chance of improving your symptoms. Studies show that 90% of women are cured or have significant improvement after these procedures.

Who will perform my procedure?

This procedure will be performed by a consultant urogynaecologist or a qualified doctor undergoing training under the direct supervision of the consultant.

Preparing for your operation

- You should maintain a sensible diet. Daily exercise in the run up to the operation will improve your recovery. A 30 minute brisk walk, three to four times a week should be sufficient. Swimming is a good alternative. Avoid alcohol and cigarettes in the month before the operation.

- Stopping smoking will benefit your health in all sorts of ways such as lessening the risk of
chest problems after your anaesthetic. By not smoking – even if it is just while you are recovering – you will bring immediate benefits to your health. If you are unable to stop smoking before your operation, you may need to bring nicotine replacements for use during your hospital stay. You will not be able to smoke in hospital. If you would like information about a smoking cessation clinic ask any of the staff.

- Discuss the operation with your General Practitioner (GP) and get him/her to review your medications. Medications such as non-steroidal anti-inflammatories (such as Ibuprofen, Diclofenac [voltarol]) need to be stopped at least seven days before the operation. Blood thinning medications such as Warfarin need to be converted to an alternative drug before the operation. Hormone replacement therapy (HRT) or the contraceptive pill should be stopped four weeks before your surgery and not recommenced until six weeks after your operation. If you are on high blood pressure medication you should arrange to have your blood pressure checked by your GP.
- If you have any symptoms of a cold or ‘flu in the days leading up to the operation you must let your surgeon know as this may necessitate the cancellation of your operation. It may cause some problems to undergo surgery if you have any sort of infection.
- In the two days before the operation take plenty of fluids. It is important to avoid dehydration in the days before the operation.

**Before your procedure**

Once the decision for the procedure has been made, patients having the procedure under a general anaesthetic will be asked to attend a pre-admission clinic, when you will meet a specialist nurse. For some women we may arrange a telephone consultation. 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. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

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

Most people who have this type of procedure will be able to go home the same day. However, it is wise to bring an overnight bag in case you have to stay overnight. Your doctor will discuss the length of stay with you.

You will need to starve for six hours before the operation and drink only clear fluids, water is best, for three hours before. The pre-admission staff will tell you what time to do this and also advise you of what time you are to come to the hospital.
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 the necessary anaesthetic and/or sedation - see below for details of this and the role of the anaesthetist in your care.
- You will be given antibiotics whilst you are asleep; this is administered intravenously (into the vein) by the anaesthetist. This is given as a preventative measure against possible infection. It is therefore important that you tell a member of staff if you are allergic to any antibiotics.
- During a retropubic midurethral sling operation, a synthetic sling is inserted through a cut in the vagina, to support the bladder entrance (urethra). The surgeon makes small cuts just above the pubic area and passes the synthetic tape through them. The tape remains permanently in place (see picture on page 2).
- During a transobturator sling operation, a synthetic sling is inserted through a cut in the vagina to support the bladder entrance (urethra). The surgeon makes two small cuts on the inside of both thighs and passes the synthetic tape through them. The tape remains permanently in place. A cystoscopy (telescope looking into bladder) is performed to check your bladder has not been damaged during this process.

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

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

Eating and drinking. Usually following surgery you will be able to drink fluids when you are ready. If you feel hungry, you can usually have something light to eat soon after the operation. 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. Avoid alcohol for the first 24 hours as a general anaesthetic may affect you more than normal.
Getting about immediately 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.

Leaving hospital. Generally, most people who have had this type of procedure under general anaesthetic will be able to leave hospital the same day. 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. You must have had something to eat and drink, been able to pass urine and have someone to take you home and be with you overnight.

Resuming normal activities including work.
For 24 hours following general anaesthetic you must not:
- drive a car or any other vehicle or cycle
- operate any apparatus or machinery – including a cooker
- do any strenuous exercise
- drink any alcohol

- Most people who have had this procedure can resume normal activities within one month. You might need to wait a little longer before resuming more vigorous activity such as carrying heavy items like shopping bags. 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. Should you require a “Fitness for work” certificate please ask your doctor.

Special measures after the procedure:
Trial of urinary voiding. When you get the sensation to void (pass urine), please inform the nursing staff so that they can provide a bed-pan liner. The voided amount will be measured and then the nurse will use a bladder scanner (like that used during pregnancy and not painful). The scanner will be placed on your abdomen (tummy) and used to measure how much urine is left in the bladder. Do not strain to void. If the bladder scanner shows that you are unable to empty the bladder sufficiently you may have the catheter replaced by the nursing staff and you will go home with this. You will be able to wear this discretely as a leg bag which can be emptied directly into the toilet. A further trial of voiding will be undertaken at an agreed interval, usually the following day. This happens on Daphne Ward (Inpatient gynaecology ward) – you will be given all the arrangements for this before you leave hospital. The nursing staff will give you all the information and equipment you will need to manage the catheter at home.

Sexual intercourse: You should refrain from sexual intercourse for six weeks following your procedure.
**Patient Information**

**Constipation:** It is important that you avoid constipation following your procedure. You may need to take laxatives to help your bowels open more easily in addition to ensuring you drink plenty of fluid and eat fruit and vegetables.

**Pelvic Floor Exercises:** It is important that you continue with the physiotherapy advice you have been given prior to your procedure.

**Pain:** Most women will still feel some diminishing discomfort when at home. Painkillers such as paracetamol and ibuprofen should help. If the pain becomes distressing, please contact your GP or us on the contact numbers listed below.

**Check-ups and results:** A telephone call will be made by the urogynaecology specialist nurse six months after discharge. However, should you feel the need to talk to a member of the team, before your follow up please contact us through our secretarial team (01223 586740 or bleep the urogynaecology Specialist nurses on 01223 245151 and ask for bleep 157 952).

**Significant, unavoidable or frequently occurring risks of this procedure**

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

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk). This is further explained in the following patient information leaflet available from the RCOG (2015): Understanding how risk is discussed in healthcare: Information for you.

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

**Serious risks:**

- There is a 1-2 in 100 chance of mesh erosion into the vagina. This may require further surgery to resolve the problem (common/uncommon).
- There is a 4 in 100 risk of damage to the bladder or the urethra (common).
- Injury to other organs such as bowel and major blood vessels has been reported. These occur in less than 1 in 100 of women (uncommon).
- 1-15 in 100 women after their operation will develop the need to pass water very often, or get little warning of needing to go to the toilet or have trouble getting to the toilet in time. This may respond to drug treatment (common).
- Following transobturator tape about 1 in 10 women have pain in the inner thigh at the site of the tape insertion. This can be difficult to resolve (common).
Frequent risks:

- There is a 4 in 100 risk of developing a clot due to bleeding in the area where the tape is placed. This will usually resolve in the few months following the procedure (common).
- 4-10 in 100 women will develop a urinary tract infection after the procedure (common).
- Immediately following surgery 5-15 in 100 women (common) may have problems with fully emptying the bladder, requiring catheterisation for a few days. It is very rare for this to be a long-term problem.

Alternative procedures that are available

- Other procedures include urethral bulking agents (injections), colposuspension and autologous fascial slings (operations).
- Many women who have undergone a period of supervised pelvic floor muscle exercise training will not require surgery.
- Absorbent products such as incontinence pants or pad may provide some patients additional ways of treating their urinary problems. Additionally, devices that are placed into your vagina may occasionally be useful for managing urine leakage, such as during physical exercise.
- The alternative to this surgery is to decide not to have surgery and the implications of deciding not to have surgery will be discussed with you.

Information and support

- Urogynaecology Nurse Practitioner.
  Telephone: 01223 245151 and ask for bleep 157 952
  08:00 – 18:00 Monday to Friday
- Clinic 24 (The Emergency Gynaecology Unit/EPU)
  Telephone: 01223 217636
  Open 08:00 – 20:00 Monday to Friday and 08:30 – 14:00 at weekends
  Closed Bank holidays
- Daphne Ward (Inpatient Gynaecology)
  Telephone: 01223 257206
  At all other times

When to seek help:

As with any procedure, complications can occur.

You should seek medical advice from your GP, clinic 24, daphne ward or the emergency department for:

- Abdominal pain, that is not relieved with the painkillers advised or that continues for more than three weeks
- Raised temperature (fever) and ‘flu-like symptoms. This may be due to infection
- Feeling faint, dizzy or unwell
- Burning and stinging when trying to pass urine—this may be due to urine infection
You should attend the emergency department immediately for:

- Pain, redness and swelling in legs-this may be a sign of DVT.
- Shortness of breath or chest pain or cough it could be due to clots that have travelled to your lungs called pulmonary embolism.

**Further information:**

- International Urogynaecological Association
  [www.iuga.org](http://www.iuga.org)
  [https://www.yourpelvicfloor.org/media/mid-urethral-slings-RV3.pdf](https://www.yourpelvicfloor.org/media/mid-urethral-slings-RV3.pdf)

- The Royal College of Obstetricians and Gynaecologists
  [http://www.rcog.org.uk](http://www.rcog.org.uk)

- Bladder and Bowel Community
  [https://www.bladderandbowel.org/](https://www.bladderandbowel.org/)
  Telephone: 08453 450165

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

Moving to the operating room or theatre
You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

General anaesthesia
During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

Regional anaesthesia
Regional anaesthesia includes epidurals, 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 and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.
Local anaesthesia

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

Sedation

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

What will I feel like afterwards?

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

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

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

What are the risks of anaesthesia?

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

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

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache

Retropubic sling for stress urinary incontinence, CF450, V4, February 2020
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.
5 ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

It is Trust policy that before we commence any treatment plan we discuss your wishes in the unlikely event there is a complication/emergency resulting from the treatment. The ReSPECT process creates a personalised recommendation for your clinical care in emergency situations where you are not able to make decisions or express your wishes. This enables your health professional to make clinical decisions and to act in your best interests and for your benefit.

The conversation helps us to understand your priorities of care and use those to develop an agreed plan that records what types of care or treatment:

- You would want to be considered for in an emergency
- You would not want to receive
- Would not work or be of overall benefit to you.

There is further information available at: ReSPECT – Recommended summary plan for emergency care and treatment: Information for patients, relatives and staff

Privacy & dignity

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

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

Other formats:

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

Document history

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Retropubic sling for stress urinary incontinence, CF450, V4, February 2020
To cure or improve stress urinary incontinence. This will not improve symptoms of frequency and urgency.

b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

Serious risks: Mesh erosion into the vagina or other organs like bladder or bowel. This may require further surgery to resolve the problem / damage to the bladder or the urethra / Injury to other organs such as bowel and major blood vessels has been reported / develop the need to pass water very often, or get little warning of needing to go to the toilet or have trouble getting to the toilet in time. This may respond to drug treatment/pain in the inner thigh at the site of the tape insertion (following transobturator tape).

Frequent risks: developing a clot due to bleeding in the area where the tape is placed. This will usually resolve in the few months following the procedure / develop a urinary tract infection after the procedure/problems with fully emptying the bladder, requiring catheterisation for a few days after surgery. It is very rare for this to be a long-term issue.

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

Retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress urinary incontinence

d) any extra procedures that might become necessary during the procedure such as:
   [ ] Blood transfusion   [ ] Other procedure (please state)

The following information leaflet has been provided:

Retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress

Version, reference and date: CF450 Version 4 January 2020
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.

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
Consent Form

Retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress urinary incontinence

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.

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: D.D./M.M./Y.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.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.Y.
Name of witness (PRINT): .................................................................
Address: .................................................................

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: ___ / ___ / ___
Use hospital identification label

Patient safety – at the heart of all we do
Addenbrooke’s Hospital | Rosie Hospital
Retropubic midurethral sling/transobturator midurethral sling for the surgical treatment of stress urinary incontinence

**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: ..............................................
**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: ..............................................
**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: ..............................................
**Signed** (Health professional): ........................................... Date: ..............................................
**Name (PRINT):** ................................................................. **Job title:** .................................................................