Patient information and consent to autologous fascial sling for 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.**

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

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

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

After the procedure we will scan the consent part of this form into your medical notes on our electronic system and you may take this information leaflet home with you so you have it to refer to.

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.

**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.**

**About autologous fascial sling**

This is a sling procedure to correct stress urinary incontinence (leaking urine when coughing, sneezing, running etc). We typically use this for people who have previously had surgery for stress incontinence. Occasionally it is used as a primary procedure.

The operation involves us making a sling from the fascia (a layer beneath your skin) of your abdomen (tummy) and using this sling to hold your urethra (the pipe from your bladder) in the correct place. It involves a cut in your abdomen and also your vagina, and is performed under a general anaesthetic.

The aim is to treat your stress incontinence by returning your anatomy to its normal position in the pelvis.

**Intended benefits**

- To prevent your stress urinary incontinence which causes you to lose urine with certain activities i.e. coughing, sneezing, running etc.
- After this procedure 60-70/100 women report improvement in their symptoms.

**Who will perform my procedure?**

This procedure will be performed by a consultant gynaecologist or a junior doctor training in this field and working under supervision.

**Preparing for your operation**

- Once you have decided to go ahead with the procedure you will be taught to self-catheterise (put a tube into your bladder to empty it) either in clinic, or by one of the gynaecology ward nurses. This is in case you have urinary retention following the procedure. If necessary we can remind you of this before you leave the hospital.
- 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.
- Discuss the operation with your General Practitioner (GP) and get him/her to review your medications. Medications such as low dose aspirin, 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 or the contraceptive pill should be stopped four weeks before your surgery and...
not recommended 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 operation**

- Most patients attend a pre-admission clinic, where you will be seen by a member of the urogynaecology team.
- At this clinic, we will ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free at any time to discuss any concerns you might have.
- You will be asked if you are taking any tablets or other types of medication, these might be ones prescribed by a doctor or bought over the counter in a pharmacy. It helps us if you bring details with you of anything you are taking (for example: bring the packaging with you).
- Gynaecology services operate an Enhanced Recovery Programme for our patients, therefore if you are not diabetic, you will be provided with nutritional carbohydrate drinks in the pre-admission clinic. These nutritional drinks are to be drunk in the 24 hours leading up to your surgery. These drinks help your wounds heal faster, reduce the risk of infection and help your recovery overall.
- This procedure involves the use of general or regional anaesthesia. See below for further details about the types of anaesthesia we shall use.
- 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.
- You will be given some thromboembolic (TED) stockings to wear before the surgery; you should wear these until you have returned to your normal activities after the operation.

**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 surgery**

- Before your procedure, you will be given the necessary anaesthetic. 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.

• The operation begins with a transverse cut across the abdomen (tummy) to allow us access to the fascia (layer beneath the skin). A strip of the fascia is removed for later use as a sling and stored in a sterile saline solution. The remaining fascia is then closed with absorbable sutures (stitches).

• Next, a cut is made in the vagina and a tunnel made on either side of the urethra (the pipe from your bladder) so that an instrument can be passed from above the fascia to the vagina.

• Using the instruments, the sling is placed beneath the urethra and secured to the fascia above.

• Both the abdominal wall and the vagina are then closed with dissolvable sutures (stitches). At the end of the operation the bladder is inspected with a cystoscope (telescope) to ensure that there have been no injuries.

• Finally an indwelling catheter (tube to empty your bladder) is put into the bladder to ensure it is kept empty and allow proper healing.

**Blood transfusion**

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

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

**After the 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, oxygen levels, check your wound site and also 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.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you do feel sick, please tell a nurse and you will be offered medication to make you more comfortable.
The general anaesthetic may make you feel lethargic for a few days and you may have some general muscular aching. Your throat may feel dry and sore but this will improve after a couple of days.

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

**Getting about immediately after the procedure.** As part of the Enhanced Recovery Programme 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.** Most people who have had this operation will be able to leave hospital after one to two nights. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion.

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

**When you can resume driving:** You need to be pain free and able to respond to any emergency situation that you may encounter especially being able to quickly brake without having any pain. It is best to check this by sitting in the car with the engine off. This may be four weeks after your operation. If in doubt check with your GP and your insurance company.

**Special measures after the procedure:**

**Trial of urinary voiding.** The catheter will be removed the evening following surgery. When you get the sensation to void (pass urine), please inform the nursing staff so that they can provide a bed-pan liner. Do not strain to void. The voided amount will be measured and then the nurse will use a bladder scanner (like that used during pregnancy and not painful) to measure how much urine is left in the bladder. If the bladder scanner shows that you are unable to empty the bladder sufficiently, you will have to start the intermittent self-catheterisation you were shown before the operation.

**Vaginal bleeding.** You may have some vaginal bleeding after the operation. This will gradually decrease over the following few weeks. You may experience a heavy bleed (as much as a period) at about 10 days after the
operation. This is normal and will usually settle within a few hours. A vaginal discharge can persist for up to four to six weeks. This may be quite heavy but does not mean that there is an infection. You should use sanitary towels and not tampons for the bleeding/discharge. If the discharge lasts much longer than six weeks, becomes heavier or offensive smelling, or you have flu-like symptoms, then please contact us on the numbers below or see your GP.

**Wound care:** The wound is closed with dissolvable stitches or surgical glue and may be covered with a dressing. If there is a dressing it can be removed the day after surgery. The wound must be kept clean and dry using a clean towel to pat it dry following your shower. We advise you to shower and avoid long soaks in the bath or swimming until it has fully healed. Occasionally the stitches can cause an irritation of the skin and we advise that you visit your practice nurse or GP approximately five to seven days after your surgery to have these removed. If the area around your wound becomes red, hot to touch or more painful than before this may be an indication of infection and we suggest you see your GP or contact Clinic 24 (The Emergency Gynaecology Unit) on the numbers listed below.

**Pain:** You may experience some soreness around the wound and a bloated feeling in your abdomen. You may also have some pressure on an abdominal nerve that is connected to the shoulder area which may make the shoulders ache. It is not unusual for the discomfort to last for up to a week. You may take painkillers, such as paracetamol or ibuprofen, which will help to relieve it. You will probably still be feeling some discomfort when you are back home. If the pain becomes distressing, please contact your GP.

**Bowels.** It is important to avoid constipation after surgery. You will be prescribed laxatives on discharge to help with this.

**Pelvic floor exercises:** It is important that you continue with the physiotherapy exercises you have been given prior to, or following, your procedure. This advice is summarised in the “Fit for Life” leaflet which you will be given by the Women’s Health Physiotherapist attached to the ward.

**Housework:** Do not lift anything heavy. This means that you will not be able to do housework for a few weeks. We generally advise complete rest for the first two weeks. After this you may gradually increase the amount you do. If you look after your house, start with gently dusting – but not moving everything around, increase to cleaning bathrooms etc, but remember you will not be able to lift a vacuum for approximately eight weeks or lift buckets of water to wash floors either. You will not be able to lift heavy washing baskets or hang out washing for a few weeks. You will be able to do some ironing after two weeks but you will not be able to put the ironing board up or down.
Cooking. You will be able to make yourself light meals when you get home but you should not lift anything heavier than a kettle of water for approximately four weeks. You will therefore not be able to do things like straining saucepans, lifting heavy dishes in and out of the oven and you will not be able to lift shopping bags or push supermarket trolleys.

Sexual Intercourse. It is safe to resume sexual intercourse after eight weeks. It is advisable to use a commercial lubricant for the first time (such as Vielle, Durex or Sylke). If you have not had a hysterectomy and still menstruate (have periods) it is still possible to get pregnant and this may have an adverse effect on the surgery and you may have to have a caesarean section delivery. You should therefore give consideration to contraception. You can discuss this with your consultant or your general practitioner (GP).

Things to be aware of:
If you develop urinary burning, frequency or urgency, offensive discharge or fever, you should see your GP.

You should continue to wear your TD stockings until you have resumed normal activities. You will be prescribed anti-clotting injections for one week following your surgery to reduce the risk of a blood clot. You will be shown how to give these to yourself before you go home.

Longer term:
Maintaining a normal weight and stopping smoking will help with long term success of this procedure.

Check-ups and results: When you are discharged from the ward, an appointment will be made for you to be seen in the urogynaecology clinic three to six months after your surgery. At this appointment you will be seen by a member of the urogynaecology team. You will be asked to complete a questionnaire so that we can assess how the operation has helped with your symptoms.

Significant, unavoidable or frequently occurring risks of this procedure
If you have a pre-existing medical condition, are obese, or have had previous surgery the 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: Understanding how risk is discussed in healthcare. Information for you.
### Term | Equivalent numerical ratio | Colloquial equivalent
--- | --- | ---
Very common | 1/1 to 1/10 | A person in family
Common | 1/10 to 1/100 | A person in street
Uncommon | 1/100 to 1/1000 | A person in village
Rare | 1/1000 to 1/10 000 | A person in small town
Very rare | Less than 1/10 000 | A person in large town

### Serious risks
- Bladder injury can occur in 3-5/100 cases (Common). This is usually resolved during the operation. After a bladder injury the patient may have to have a catheter for 10 days.
- As with any major operation there is a small risk of a deep vein thrombosis, pulmonary embolus or other organ damage.

### Frequent risks
- Wound haematoma (blood clot), infection or hernia can occur in 15/100 cases (Very common)
- Urinary retention (unable to pass urine) requiring catheterisation occurs in 25-35/100 cases (very common). The majority resolve over six months. Approximately 4/100 cases need further surgery to correct this problem or continue to practice clean intermittent self-catheterisation.
- An increase in urinary frequency and urgency is noted in 1-15/100 cases (Very common/common).

### Alternative procedures that are available
- Other procedures include urethral bulking agents (injections), colposuspension (a specific operation) and using other synthetic (man-made) sling operations.
- Physiotherapy. Many women, who have undergone a period of supervised pelvic floor muscle exercise training, will not require surgery.
- Occasionally patients will be offered drug treatments (Duloxetine), specifically to treat stress incontinence.
- Absorbent products such as incontinence pants or pads may provide some patients additional ways of treating their urinary problems. Additionally, devices that are placed into your vagina or urethra (pipe from the bladder) may occasionally be useful for managing urine leakage, such as during physical exercise.
- If you decide not to have this surgery, the implications will be discussed with you.

### Information and support
- Urogynaecology Nurse Practitioner.
  Telephone: 07912362349
  08:00 – 16:00 Monday to Friday
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 to your surgery.
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  
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 biomedical 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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Patient Information

Autologous fascial sling for stress urinary incontinence

To prevent your stress urinary incontinence which causes you to lose urine with certain activities i.e. coughing, sneezing, running etc.

After this procedure 60-70/100 women report improvement in their symptoms.

Serious risks: Bladder injury can occur in 3-5/100 cases (Common). This is usually resolved during the operation. After a bladder injury the patient may have to have a catheter for 10 days. As with any major operation there is a small risk of a deep vein thrombosis, pulmonary embolus or other organ damage. Frequent risks: Wound haematoma (blood clot), infection or hernia can occur in 15/100 cases (Very common). Urinary retention requiring catheterisation occurs in 25-35/100 cases (very common). The majority resolve over six months. Approximately 4/100 cases need further surgery to correct this problem or continue to practice clean intermittent self-catheterisation. An increase in urinary frequency and urgency is noted in 1-15/100 cases (Very common/common).

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

Autologous fascial sling for stress urinary incontinence

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:
   Autologous fascial sling for stress incontinence

   Version, reference and date:  Version 2, CF452, April 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.M.Y.Y.
Name (PRINT):  Time (24hr):  H: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

Patient safety – at the heart of all we do

Addenbrooke's Hospital  |  Rosie Hospital

Autologous fascial sling for stress urinary incontinence, Version 2, April 2015
Consent Form

Autologous fascial sling for 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: __/__/YYYY

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: __/__/YYYY

Relationship to patient: ..............................................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signed (Witness): ................................................................. Date: __/__/YYYY

Name of witness (PRINT): .............................................................

Address: ..................................................................................

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

Autologous fascial sling for 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: ....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: ..........................................................