Patient Information

Patient information and consent to reversal of Hartmann’s operation

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 otherwise your operation may have to be postponed or cancelled.

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

- **It is important that you bring this consent form with you when you are admitted for surgery.** You will have an opportunity to ask the surgeon or anaesthetist any questions 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 colorectal specialist sisters on **01223 217923** if you have any questions or concerns about this procedure or your appointment.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

About a reversal of Hartmann’s operation

You have been recommended to have reversal of Hartmann’s operation to enable your bowel to be re-joined and get rid of the present stoma / colostomy. The procedure will be performed under general anaesthetic.

You have already had an operation called a Hartmann’s procedure where part of your large bowel (colon) was removed and a stoma (a colostomy or occasionally an ileostomy) created. The lower end of the large bowel (rectum) has been closed and left inside your abdomen.

In this reversal of Hartmann’s operation, the aim is to take down the stoma and join it back to the closed lower end (rectum). This will re-establish the continuity of your bowel to allow passage of stool (bowel motions) through the back passage (anus) again.
Although the aim of this operation is to remove the stoma, a small minority of patients may require a smaller temporary stoma (ileostomy) for three to six months to enable the new join to heal safely. If this is likely, the stoma therapy nurse will see you to advise you about an ileostomy and to place a mark for a suitable position for the ileostomy on the right side of your abdomen.

**Intended benefits**

The aim of the surgery is to remove the stoma, re-join the cut ends of bowel and enable passage of stools/motions via the back passage again. For most patients this will be the last operation relating to this episode.

**Who will perform my procedure?**

Your surgery will be performed by a surgeon with particular skills and training in bowel surgery. This is usually a consultant colorectal surgeon or senior specialist registrar under consultant supervision.

**Before your admission**

Most patients attend a pre-admission clinic, where you will meet one of the specialist nurses. 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 may have.

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 relevant packaging (if available) with you. You may have a blood test and ECG performed, as well as swabs taken for MRSA.

This procedure involves the use of anaesthesia but spinal or local anaesthetics are often used as well for pain control. 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 need to stay in hospital for three to six days after the operation. Sometimes you will need to stay for longer than usual. Your doctor will discuss this with you before you decide to have the procedure. Those with medical problems or special needs may need to stay in hospital longer.

**Day of surgery admission**

Most patients are admitted on the day of surgery. If you need to have a completely empty bowel you should take the ‘bowel prep’ (given to you at the pre-admission clinic) at home the previous day. You may also be asked to have an enema to clear the back passage prior to surgery. These preparations are not always necessary.
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
Before your procedure, we will give you the necessary anaesthetic - see below for more details. Your anaesthetist will also discuss post-operative pain relief with you and if you are having a spinal or epidural this may be put in before you are anaesthetised. You will need to have a catheter inserted once you are asleep so we can measure urine output. This will be removed within the first few days after the operation.

The operation may be done either with an open approach via an incision or by laparoscopic keyhole approach. Your surgeon will discuss the best way of doing your surgery with you. If you are offered a keyhole operation, there is a chance that it may not be possible to do the operation safely by keyhole surgery, in which case the operation will be carried out through an incision.

The open approach usually uses a vertical incision through the previous scar in the abdominal wall. In the laparoscopic keyhole approach, three small holes are made in the tummy wall each about 1cm long. Through these we inflate your tummy with carbon dioxide gas which is harmless. We then use special long instruments and operate visualising on a TV screen by a miniature camera inserted through one of the three keyholes. Sometimes additional keyholes may have to be made if necessary.

The first part of the operation involves freeing the loops of bowel from adhesions (scar tissue which sticks bowel together or to other structures inside the belly (abdomen)). The closed lower end of bowel also needs to be found and freed to allow a join to be made.

The stoma is freed up from its attachment to the skin by making an incision around it on the abdominal wall. The upper end of the bowel and the rectum are then joined together either using special stapling instruments or sutures (stitches). If a smaller temporary stoma is thought to be necessary, then this will be made.

At the end of the operation the abdominal wall is stitched together at the site of the previous stoma and at all incisions. The skin is closed, usually with dissolvable
sutures, so there is no need for the stitches to be removed after the wound heals. Glue dressings are used to seal the skin. Occasionally a temporary drain may be placed which is removed a couple of days after surgery.

**After the procedure**

Once your surgery is complete, 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. You may be given oxygen via a facemask, fluids via a drip and appropriate pain relief until you are comfortable enough to return to your ward.

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

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 major surgery.**

**Enhanced recovery**

Where possible we make use of ‘enhanced recovery’ principles to minimise the impact of surgery on the body and enable a rapid return to normal activity. There are many aspects to this process which includes pre-operative (before), intra-operative (during) and post-operative (after) procedures. We aim to minimise pain, perform careful surgery, avoid unnecessary drips, tubes and drains, enable you to eat and drink straight after your operation, encourage early mobilisation to stimulate recovery and allow you to go home soon and safely. We want you to be involved with this and need your help to improve your recovery.

**Eating and drinking.** After your operation you may start drinking straight away. You will be encouraged to drink and eat as much as you can tolerate over the next few days. You will not be forced to eat if you do not feel like it.
**Patient Information**

**Getting about after the procedure.** We will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. You will have daily injections which reduce the chance of blood clotting in your legs (deep venous thrombosis) and lungs (pulmonary embolism). Typically, you will be helped out into a chair the following day. You will be given assistance from the nurses and physiotherapists.

**Leaving hospital.** Most people who have this type of procedure will need to stay in the hospital for about three to six days. Sometimes complications arise and these will delay discharge. When you go home we would expect you to be mobile, comfortable and able to eat safely. 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 their normal activities after six to eight weeks. You might need to wait a little longer before resuming more vigorous activity. Lifting heavy objects should be avoided for at least six weeks to reduce the chance of hernias. When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. Please ask your doctor for his/her opinion.

**Special measures after the procedure**

**Pain Control:** this is usually with either an epidural or patient-controlled analgesia (see below for details).

**Check-ups and results:** Before you leave hospital, you will be given details of when you need to return to the outpatient clinic. At this time, we can check your progress and discuss with you any further treatment.

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

Reversal of Hartmann’s operation is a major operation and there are certain risks known to be associated with it. These include the risks of surgery in general, the risks particularly associated with bowel surgery and the risks of anaesthetic described in more detail under the section on anaesthesia.

The general risks of surgery include problems with the wound (for example, infection or poor healing), breathing (for example, chest infection), heart (for example, abnormal rhythm or occasionally a heart attack), blood clots (for example, in the legs or occasionally in the lung) or kidney function (for example, kidney failure).

There is a risk of leakage where the bowel has been joined (‘anastomotic leak’) after reversal of Hartmann’s procedure. The risk of leakage depends on several factors including how close the join is to the anus, medical problems, adhesions (scar tissue),

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etc. The risk of a leak is about 5% but may be higher if the join is low or technically
difficult. If the risk is thought to be high, you may need a temporary ileostomy to
allow the join to heal safely. If a leak occurs, further intervention with drains placed in
the x-ray department or occasionally surgery may be required.

Other risks specifically related to reversal of Hartmann’s operation include transient
blockage of the bowel, bleeding or infection in the abdominal cavity. Rarely further
surgery is required to put right such complications.

It is very occasionally apparent during the operation that it is not possible or safe to
reverse the stoma. The chances of this are about 1%. In this case, the stoma would
be left and not reversed.

Injury to other organs (for example, small intestine) may require repair. The risk of
this is greater if there is a lot of scar tissue from the previous surgery.

A small minority of patients undergoing reversal of Hartmann’s operation may need a
smaller temporary stoma to cover the join. Such patients will need to have a further
operation to close this stoma once the join has healed. This will usually be after three
months.

Bowel function may be erratic or more frequent after reversal of Hartmann’s
operation. The majority of patients settle into a regular bowel pattern by about a
month after the operation. Occasionally patients may suffer frequency or urgency
after this type of surgery.

Long-term risks include hernias in the surgical incisions and bowel blockages from
adhesions (scar tissue).

Most people will not experience any serious complications from their surgery. The
risks increase for the elderly or overweight, for smokers, and for those who already
have heart, chest or other medical conditions such as diabetes or kidney failure. There
is a small risk of death. You will be cared for by a skilled team of doctors, nurses and
other health care workers who are involved in this type of surgery on a daily basis.
Any problems that arise can be rapidly assessed and appropriate action taken.

Alternative procedures that are available

The majority of patients with Hartmann’s procedure undergo reversal particularly as
they are keen to get rid of the stoma. The only other alternative is not to undergo the
operation for the reversal and keep the stoma.
Information and support

You might be given some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including the doctor or ward staff.

If you have further questions please contact one of the colorectal specialist sisters on 01223 217923.

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, 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. They 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.**

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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. Regional anaesthetic 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

Pain relief

Pain relief (analgesia) after major bowel surgery may be provided by regional analgesia, either by an epidural, caudal or a spinal injection (depending upon your particular operation), or by strong pain killers such as morphine, usually administered into the vein by a patient controlled analgesia system. The latter is a system whereby you control the administration of pain killer into your intravenous drip by pressing a button. Local anaesthetic injections around nerves which supply the abdominal wall may also be used, for example TAP blocks.

Your anaesthetist will discuss pain relief with you prior to surgery, along with the risks and benefits of the techniques.

The risks of the epidural and spinal pain relief are similar to the risks of regional anaesthesia, as listed above.

Patient information leaflets are available for epidural and pain controlled analgesia from our website or can be provided upon request from the pre-admission clinic.

Other analgesics may also be administered as injections, tablets or suppositories (if appropriate), particularly after a day or two, when the pain will be decreasing and the epidural or patient controlled analgesia are stopped.

This hospital has an ‘Acute pain team’, who are a team of nurses and anaesthetists who specialise in pain relief after surgery. One of the team may visit you after your surgery to help and advise the ward team with the management of any pain you may have.
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.
**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. However, if 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, this will be carried out. 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.

**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.

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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.

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**Document history**

Authors: General surgery department  
Department: Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk  
Contact number: 01223 245151  
Publish/Review date: November 2015 / November 2018  
File name: CF458_Reversal_Hartmanns_v2.doc  
Version number/Ref: 2 / CF458

Reversal of Hartmann's operation, CF458, V2, November 2015
The aim of the surgery is to remove the stoma, re-join the cut ends of bowel and enable passage of stools/motions via the back passage again.

Full details are set out in the information and include:

- risks of this surgery, of surgery and anaesthesia in general; problems with this wound, breathing, heart, blood clots or kidney function; risk of leakage where bowel joined (anastomotic leak); transient blockage of the bowel, bleeding or infection in the abdominal cavity; it may not be possible or safe to reverse the stoma; injury to other organs (e.g. small intestine) may require repair; the need for a small temporary stoma to cover the join; erratic bowel function; hernias in the surgical incision and bowel blockages from adhesions (scar tissue).
- Risks may increase depending on your health, age, whether or not you smoke and your existing medical condition.
- 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:
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:

Reversal of Hartmann’s operation

Version, reference and date: CF458, version 2, November 2015

or I have offered the patient information about the procedure but this has been declined.

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
Reversal of Hartmann’s operation

4 Use of Tissue
a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

☐ Yes ☐ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

☐ Yes ☐ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): __________________________________________________________ Date: __.D./.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./.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./.M./Y.Y.Y.Y.

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

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

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Reversal of Hartmann’s operation

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: …………………………………………………