Patient information and consent to closure of ileostomy

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 closure of your ileostomy

You have been recommended surgery to close a loop ileostomy (stoma/bag). This type of stoma is usually created as part of an operation to divert faecal matter away from the bowel in order to allow a join (anastomosis) in the bowel to heal. Once healing has taken place, the stoma may be closed under general anaesthesia.

In preparation for the ileostomy closure, you may have had an enema x-ray to check the join in the back passage. At the time of surgery, the join is often examined to ensure it is widely open. Sometimes the join needs to be stretched and if so this will be done while you are under the anaesthetic.

Intended benefits

The benefit of this operation is that you will be able to open your bowel via the back passage (anus) again without the need for a stoma bag.

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Who will perform my procedure?

This procedure will be performed by a surgeon with particular skills and training in bowel surgery, either a consultant surgeon or senior specialist registrar under consultant supervision.

Before your admission

You will need to attend the pre-assessment clinic, which is usually run by 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 general anaesthesia. Local anaesthetic is often used to control pain. See below for further details about the types of anaesthesia we may use.

Most people who have this type of procedure will need to stay in hospital for one to three days. 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

You would normally come into hospital in the morning of the day of the operation after fasting overnight. There will be no need for you to alter your diet or for any preparation of the bowel.

During the procedure

Before your procedure, you will be given the necessary anaesthetic. This will usually be a general anaesthetic - see below for details of this. Your anaesthetist will discuss post-operative pain relief with you.

The surgeon will discuss with you whether the back passage needs to be examined under anaesthetic as a final check prior to closure of the stoma.

A small incision (cut) will be made around the ileostomy (stoma). The stoma is then freed from the surrounding skin and abdominal (tummy) wall. The hole in the bowel is then joined together, either by stitches or staples. At the end of the operation the abdominal wall is stitched together and then the skin is closed, often with stitches. A dressing is then applied on top of the skin.
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 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.

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.

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**Eating and drinking.** After this procedure, you may drink water straight away. Because the bowel beyond the ileostomy has not been in circuit for a long time, it can be narrowed and not stretch up to let through what you eat and drink straight away. This can lead to bloating and at its worst some vomiting. It is usually a good idea to start gently with fluids and build up to a normal diet once you are passing wind or opening your bowels.

**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. This will help to improve your recovery and reduce the risk of certain complications. You will have daily injections which reduce the chance of blood clotting in your legs (DVT). Typically, you will be able to get up several hours after the operation. If we think you will have problems getting about, we will arrange for extra assistance, for example nursing help and physiotherapy.

**Leaving hospital.** Most people who have had this type of procedure under general anaesthesia will be able to leave hospital after one to three days. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure, how quickly your bowels start to work again, and your doctor's opinion.

**Resuming normal activities including work.** Most people who have had this procedure can resume their normal activities after two 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 general 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:** At first the bowel motion will tend to be loose and frequent. You may also experience the need to defaecate urgently, or even have ‘accidents’．There is no need to be concerned if this happens, as it may take some weeks for the bowel to settle into a regular pattern again. You will be given more detailed information about any special measures you need to take after the procedure. You will also be given information about things to watch out for that might be early signs of a problem (for example, infection).

**Check-ups and results:** Before you leave hospital, you will be given details of when you need to return to the out-patient clinic. At this time, we can check your progress and discuss with you any further treatment and recommendations.
**Significant, unavoidable or frequently occurring risks of this procedure**

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 sometimes in the lung) or kidney function (for example, kidney failure).

Risks specifically related to this operation include infection at the ileostomy closure site or inside the abdominal cavity, leakage from the join in the bowel, injury to the bowel and temporary blockage of the bowel. Rarely, further surgery is required to put right such complications.

Infection in the wound normally shows as pain and redness around the area. The wound may need to be opened or antibiotics given if this happens. The risk of wound infection is 5-8%.

There is a risk (in about 1 in 50 (2%) cases) of leakage where the bowel has been joined (‘anastomotic leak’) if it does not heal properly after ileostomy closure. 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 the operation include transient blockage of the bowel, bleeding or infection in the abdominal cavity. Injury to other organs (for example, the small intestine) may require repair. The risk of this is greater if there is a lot of scar tissue from previous surgery.

Bowel function may be erratic or more frequent after stoma closure but most patients settle into a regular pattern of bowel function by about a month after the operation. Occasionally patients may suffer incontinence, frequency or urgency. Some of these problems may be permanent and often result from the surgery when the ileostomy was made.

Long-term risks include hernias in the surgical incision and bowel blockages from scar tissue.

Most people will not experience any serious complications from 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 very small risk of death (less than 2%). You will be cared for by a skilled team of doctors, nurses and other health care workers who are involved daily in this type of surgery. Any problems that arise can be rapidly assessed and appropriate action taken.
Alternative procedures that are available

Surgery is the only method available to close the stoma. The only alternative is not to have this operation either if you are too unwell for an operation, or if you prefer to keep the stoma and do not want another operation.

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 doctors or other 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’ before 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 be asked to 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 going to have.*

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, a 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 with you 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.

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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.

How will I feel 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 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. 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

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Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
Damage to the eyes
Heart attack or stroke
Serious allergy to drugs
Nerve damage
Death
Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)

**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 before 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’, which consists 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.

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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.

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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Closure of ileostomy

Patient’s side: left / right or N/A

Consultant or other health professional responsible for your care

Name and job title: .................................................................

□ Any special needs of the patient (e.g. help with communication)? .................................................................

Please use ‘Procedure completed’ stamp here on completion:

Statement of health professional (details of treatment, risks and benefits)

I confirm I am a health professional with an appropriate knowledge of the proposed procedure, as specified in the hospital's consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure (please state)
   • the benefit of this operation is that you will be able to open your bowel [and that it] will work via the back passage (anus) again without the use of a stoma bag.

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

Full details are set out in the information leaflet and include:
   • general risks of surgery (poor healing, heart problems, blood clots or kidney function)
   • infection at the closure site, abdominal cavity or in the wound
   • risk of leakage (‘anastomotic leak’)
   • transient blockage of the bowel; bleeding or infection of the abdominal cavity
   • erratic bowel function, incontinence
   • hernias in the surgical incision and bowel blockage from adhesions (scar tissue).
   • Risks may increase depending on your own health, age, whether or not you smoke and your existing medical condition.

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.
Closure of ileostomy

2 The following information leaflet has been provided:

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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: ________________

Name (PRINT): __________________________ Time (24hr): ________________

Designation: __________________________ Contact/bleep no: __________________________

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

☐ Yes ☐ No

2 Photography, Audio or Visual Recording
a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

☐ Yes ☐ No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

☐ Yes ☐ No

3 Students in training
I agree to the involvement of medical and other students as part of their formal training.

☐ Yes ☐ No
Consent Form

Closure of ileostomy

4 Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research. □ Yes □ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records. □ Yes □ No

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

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

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

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File: in the procedures and consents section of the casenotes.
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D  Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): _______________________________ Date: ____________
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: __________________