Patient information and consent to surgery for rectal prolapse

**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 telephone number 01223 217923** if you have any questions or concerns about this procedure.

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

**About rectal prolapse surgery**

Your surgeon has recommended you undergo an operation to repair a prolapse of the rectal wall to prevent it bulging down out of the anal canal.

Rectal prolapse is the term used to describe the protrusion of the back passage down through the anal canal. Often this is first noticed by patients after a bowel movement. The prolapse may return back inside of its own accord. As the condition progresses, rectal prolapse may occur with everyday activities such as walking or even be present continuously. The rectal prolapse can cause pain, constipation, faecal incontinence, mucus discharge or bleeding. When the prolapse is outside for prolonged periods it can weaken the muscles of the anal canal.

Surgery for rectal prolapse aims to prevent the lax rectal wall from bulging down through the anal canal. Broadly there are two approaches to surgery; the perineal and abdominal approach.

Surgery for rectal prolapse, CF460, V2, November 2015
Perineal approach
The rectal prolapse can be pulled out through the anal canal and operated on from below (termed ‘perineal approach’). The main perineal operations are the Delorme’s procedure and the Altemeier procedure (explained later in this leaflet).

Abdominal approach
By operating from within the abdomen the rectum can be hitched up to prevent it prolapsing down (termed ‘abdominal approach’). Abdominal approaches can be carried out either through conventional open wounds or by laparoscopic (keyhole) surgery. The rectum is fixed (‘rectopexy’) with either sutures or mesh. Occasionally, it may be planned to remove part of the colon as well (‘resection rectopexy’).

The choice of surgery depends on many factors including age, other health issues, presence of incontinence, surgeon preference and the size of the prolapse.

Intended benefits
The procedure aims to stop the rectum prolapsing down through the anal canal.

Who will perform my procedure?
This procedure will be performed by a consultant or an appropriately trained and supervised specialist registrar.

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. 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 one night. Sometimes you will need to stay for longer than usual. Your doctor will discuss this with you before you decide to have the procedure.

Day of surgery admission
Most patients are admitted on the day of surgery. Most patients will need an enema...
on the ward when admitted to clear the lower bowel prior to surgery.

**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, you will be given the necessary anaesthetic and/or sedation - see below for details of this and the role of the anaesthetist in your care.

Delorme’s procedure involves stripping the inner lining from the surface of the prolapsing rectum. The rectal muscle wall is then stitched to itself inside the anal opening. Scar tissue then prevents the prolapse returning.

Altemeier’s procedure involves completely removing the segment of prolapsing rectum and then joining the bowel together at the anal canal.

Both the Delorme’s procedure and Altemeier’s procedure involve internal wounds. These are not visible on the outside but may give some bruising around the anus.

Abdominal approach operations may either be done through an incision on the abdominal wall or with the use of keyhole (‘laparoscopic’) surgery. Stitches or an artificial mesh are used to fix the rectum higher up in the pelvis and prevent it prolapsing down. For some patients it may also be advisable to remove a segment of the large bowel just above the rectum with a join (‘anastomosis’) made in the bowel. The wounds on the abdominal wall will be closed with absorbable stitches and dressed either with some skin glue or simple dressings.

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.

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 drink and eat as soon as you feel like it. As long as your body will accept it this will be good for you. If you feel sick or bloated then you should cut back on oral intake until you feel better. You should expect to have your bowels open within one to three days and this may be uncomfortable at first. A small amount of bleeding is possible.
Getting about after the procedure. After this procedure, we will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. Typically, you will be able to get up after four hours. If we think you will have problems getting about, we will arrange for extra assistance, for example nursing help and physiotherapy advice/exercises.

Leaving hospital. Most people who have had this type of procedure under general/spinal anaesthesia will be able to leave hospital after one or two days. 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 two weeks. You might need to wait a little longer before resuming more vigorous activity. Heavy lifting should be avoided for six weeks. 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: It is important to avoid or prevent becoming constipated. You will usually be provided with stool softeners and painkillers on discharge. If you experience increasing pain, fevers, or your bowels are not working within three days of the procedure, you should contact your GP or one of our clinical nurse specialists on 01223 217923.

Check-ups and results: Before you leave hospital, we will give you details of when you need to return to see us, for example at an 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

‘Minor’ complications can complicate up to one in three rectal prolapse operations. These complications include a simple wound infection, bruising around the bottom or finding it difficult to pass urine after the operation. These problems are simple to treat, for example simple dressings, and do not require further surgery or having to stay in hospital for a prolonged period.

‘Major’ complications can unfortunately complicate any operation. These complications are described as major because they may be life threatening, require second operations, admission to an intensive care unit and lead to prolonged treatment in hospital. These complications are unusual with prolapse surgery. They include significant bleeding, serious infections including chest infections, blood clots in the leg (deep venous thrombosis) going to the lungs (pulmonary embolus) and heart problems such as a heart attack. The individual risk of these types of problems is dependent on a patient’s age and other medical conditions. Your surgeon/anaesthetist will be able to inform you of your individual risk.
to give you an approximate level of risk for these types of complication. A number of measures are taken before, during and after the operation to minimise these risks. Your level of risk will also influence the surgeon as to which type of operation is recommended.

Some major complications are specifically associated with rectal prolapse surgery. The risk of this is one to two in 100. If a join is made in the bowel with a resection rectopexy or Altemeier procedure, then failure of healing of the join may lead to life-threatening infection. These complications may require second operations and a colostomy (bowel bag). Inadvertent damage to the rectum during dissection can also cause serious infections. If this occurs during a Delorme’s procedure, your surgeon may need to carry out an Altemeier procedure instead for safety reasons.

Rectal prolapse can recur after prolapse operations. The risk specific to your operation will be discussed with you by your surgeon, but can be as high as one in five. It is usually a balance between the risk of the procedure and the chances of recurrent prolapse that influences your surgeon’s recommendation about the choice of repair method. If the rectal prolapse recurs, further surgery can be performed.

Rectal prolapse operations can alter an individual’s bowel habit causing them to go more frequently or have the opposite effect and lead to constipation. This can be difficult to predict before surgery. These symptoms may be improved with laxatives or anti-diarrhoea agents but can be a long-term problem.

The effect of surgery on incontinence (leakage of faeces or gas) is unpredictable. Some patients do see an improvement in incontinence symptoms. This should not be assumed prior to the operation and is not a specific aim of the operation. Chronic (longer than six months) pelvic pain can complicate rectal prolapse operations. One to two in 100 patients undergoing rectal prolapse surgery may have pain which interferes with their daily lives.

For patients who have a fine permanent mesh used to hitch up the rectum in the pelvis, complications of infection, erosion of the mesh into the vagina or rectum chronic pain can lead to the mesh needing to be removed with further surgery.

Risks associated with your type of anaesthetic/sedation are outlined below.

Most people will not experience any serious complications from their surgery. The risks increase for the elderly or overweight and for those who already have heart, chest or other medical conditions such as diabetes or kidney failure. There is a tiny 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

Rectal prolapse is not a condition which will heal by itself. There are no effective drug treatments to reduce the prolapse. The effects of the prolapse can, to some extent, be treated with simple measures such as diet and stool bulking agents to address constipation or incontinence pads to manage incontinence. Rectal prolapse in itself rarely has serious consequences and may be left alone out of choice.

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 being taken 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. 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 Surgery for rectal prolapse, CF460, V2, November 2015
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

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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](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 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 for rectal prolapse, CF460, V2, November 2015
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.

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Patient Information

**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 may 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.

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Surgery for rectal prolapse, CF460, V2, November 2015
Surgery for rectal prolapse

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

Patient Information

The procedure aims to stop the rectum prolapsing down through the anal canal.

Full details are set out in the information leaflet and include:

- wound infection, bruising, difficulty in passing urine
- significant bleeding, infections, blood clots, heart problems
- failure of healing of the join may lead to life threatening infection
- rectal prolapse, perhaps leading to alteration of bowel habits
- unpredictable effects of surgery on incontinence
- chronic pelvic pain can complicate rectal prolapse
- if applicable, complications related to infection of mesh used in the rectum or erosion of the mesh.
- risks associated with anaesthesia or your own health, age or underlying medical condition.

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 procedure aims to stop the rectum prolapsing down through the anal canal.

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

Full details are set out in the information leaflet and include:

- wound infection, bruising, difficulty in passing urine
- significant bleeding, infections, blood clots, heart problems
- failure of healing of the join may lead to life threatening infection
- rectal prolapse, perhaps leading to alteration of bowel habits
- unpredictable effects of surgery on incontinence
- chronic pelvic pain can complicate rectal prolapse
- if applicable, complications related to infection of mesh used in the rectum or erosion of the mesh.
- risks associated with anaesthesia or your own health, age or underlying 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:
Surgery for rectal prolapse

2 The following information leaflet has been provided: Surgery for rectal prolapse

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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

Surgery for rectal prolapse

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: __/__/______
Name of patient (PRINT): .................................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.

Signed: ........................................................................................................ Date: __/__/______
Relationship to patient:

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

Signed (Witness): ........................................................................................................ Date: __/__/______
Name of witness (PRINT): .................................................................
Address:

Patient safety – at the heart of all we do

Addenbrooke's Hospital | Rosie Hospital

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D  Confirmation of consent

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

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

Please initial to confirm all sections have been completed:

E  Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: …..D.../…M.../…Y...Y...Y...
Name (PRINT): ...........................................................................

Or, please note the language line reference ID number:

F  Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

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

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