Patient Information

Patient information and consent to Uterine Artery Embolisation

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.
- Please read this information carefully, you and your health professional will sign it to document your consent.
- It is important that you bring the consent form with you when you are admitted for your procedure. You will have an opportunity to ask any questions from the radiologist when you are in radiology. You may sign the consent form either before you come or when you are admitted.
- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x-rays or test results.
- Simple painkillers such as paracetamol and ibuprofen may be required when you are at home. It is suggested that you discuss with your pharmacist and have a seven day supply of these medications at home to take as you need according to the instructions.
- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. 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 Radiology Administrator on telephone number 01223 348920 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.

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).

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However, the person undertaking the procedure will have the relevant experience.
All information we hold about you is stored according to the Data Protection Act 2018 and the resultant General Data Protection Regulations (GDPR).

About uterine artery embolisation

Uterine artery embolisation is a treatment for uterine (womb) fibroids. Uterine fibroids are common benign tumours, found in up to 80% of women before the time of menopause. Whilst many women will not have symptoms about 25% of women with fibroids suffer from heavy or painful menstrual bleeding, pressure and discomfort in the pelvis though rarely pain, and may experience difficulty conceiving.

The uterine arteries are the two main arteries which supply the uterus (right). Uterine artery embolisation is a procedure which blocks this blood supply. The uterine arteries are accessed by an artery in the groin or at the wrist and are injected with fluid containing thousands of tiny particles, blocking the blood supply. Once the uterine arteries are blocked, blood is stopped from reaching the fibroids, causing them to shrink. This reduces the symptoms from the fibroid, such as pressure and bleeding. The procedure is less invasive than surgery and has a shorter recovery time.

Intended benefits

Uterine artery embolisation will reduce the size of fibroids, leading to an improvement in symptoms such as pain/pressure and heavy menstrual bleeding.

Who will perform my procedure?

This procedure will be performed by an Interventional Radiologist, a specialist doctor who will be assisted by a Radiographer and a Nurse.

Preparing for your procedure

Discuss the procedure with your GP and ask him/her to review your medications. Blood thinning medications such as warfarin need to be converted to an alternative drug before the operation. The oral contraceptive pill, hormone replacement therapy (HRT) or tamoxifen should be stopped four weeks before your procedure and not recommenced until six weeks after. If you are on hypertension (high blood pressure) medication you should arrange to have your blood pressure checked by your GP.

If you are due to have a further GnRH (Zoladex) injection we ask you not to do so as this should not be taken within two months of the procedure or preferably from when you are first listed for the procedure (NICE 2007).
Similarly patients taking ulipristal (Esmya) should stop two months in advance of admission. You will need to make alternative contraceptive choices to avoid getting pregnant before the procedure. Your GP or local sexual health clinic can help with this.

If you have any symptoms of a cold or ‘flu in the days leading up to your admission, you must let the Radiology Administer know as this may necessitate the cancellation of your procedure.

**Before your procedure**

- To make sure that uterine embolisation is the best treatment for you and to plan the procedure, you will undergo an MRI scan of the pelvis before. This is the most helpful type of imaging in determining the size and site of the fibroid(s). In particular, we will generally advise against embolisation if the fibroid is largely on the outside of the uterine wall (pedunculated) or largely in the cavity (submucous) as this is more likely to give rise to complications from embolisation (see below).

- Once you have had an opportunity to discuss the procedure with your Consultant and have decided to go ahead, you will have a telephone consultation with a Radiology Nurse. This is a good opportunity for you to ask any questions about the procedure, but please feel free to discuss any concerns you might have at any time.

- We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the ward staff about all the medicines you use. It may be possible for you to take your regular medication yourself (self-medicate), please ask your nurse. When you are on the ward your nurse will complete a Self-Administration of Medication (SAM) form in your electronic notes.

- You are allowed to eat a light breakfast/meal before you are admitted to hospital.

- You will be admitted to Daphne Ward in the Rosie Hospital under the care of your gynaecologist on the day of the procedure. A doctor will clerk you in (check your past medical history and what medicines you take). Please let them know if you have any allergies, especially if you have previously reacted to intravenous contrast medium (the dye used in CT scans). A cannula (a small plastic tube) will be inserted into one of your veins and attached to a morphine PCA (Patient Controlled Analgesia) pump which will provide pain relief during and after the procedure. If you would like more information about a PCA please ask the nursing staff who will be able to provide an information leaflet.

- We will perform a urine pregnancy test prior to the procedure. This is because uterine artery embolisation should not be performed in early pregnancy (RCOG & RCR 2013).

- You will be given thromboembolic (TED) stockings to wear to help prevent blood clots forming in the leg veins.
• You will be transferred on your bed from the ward to the radiology department, where a specially trained radiologist performs the procedure. Prior to the procedure you will be given additional pain relief including paracetamol solution given via your cannula and a voltarol (diclofenac) suppository into your rectum (back passage). The procedure usually takes approximately 1 hour, after which you are then transferred back to the ward.

• Most people who have this type of procedure will need to stay in hospital for one night. Your doctor will discuss the length of stay with you.

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

During the procedure
• You will be awake during the whole procedure. You will need to lie flat on your back, so if you have any difficulties with this please inform us know beforehand. It is a sterile procedure, so the radiologist will wear a surgical gown and gloves and a drape will be applied to the groin area.

• Local anaesthetic is applied to the area in your groin or wrist where a small incision is made to allow a narrow cannula to be inserted into the main arteries. This may sting but this only lasts for a few minutes. X-rays are used as the cannula is advanced to make sure it has reached the uterine arteries. Through this cannula, small particles are injected into the arteries which block smaller arteries, causing the fibroids to shrink. This may cause a warm sensation. If you experience any pain during the procedure you can press your PCA button.

• Sometimes it is not possible to reach the artery on the other side, so another incision on this side may be needed. At the end of the procedure firm compression will be applied to the incision sites to stop bleeding.

• It is difficult to predict exactly how long the procedure will take but generally it takes up to one hour.
After the procedure

What happens immediately after the procedure

- The nursing staff will take frequent observations of your pulse, blood pressure and will look at the puncture site in your groin or wrist and check for any vaginal bleeding / discharge.
- After the procedure you will likely experience a crampy period-like pain in your lower abdomen (tummy). The morphine PCA pump will help with this. You may also feel sick and can vomit, please ask for anti-sickness medication if you need to.

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.

What happens in the days and weeks after the procedure

**Eating and drinking.** After this procedure, you can eat when you feel able once you are back on the ward.

**Getting about immediately after the procedure.** After the procedure you will be taken back to the ward on your bed where you will have to lie flat for 4 hours. After which the nursing staff will advise you on mobilising.

**Leaving hospital.** Generally most people who have had this operation will be able to leave hospital after one day. However, the actual time that you stay in hospital will depend on your general health, how quickly you are recovering from the procedure and your doctor’s opinion.

**Resuming normal activities including work.** Usually you can resume normal activities after one to two weeks. You should avoid strenuous exercise for two weeks and you should not drive until your abdominal discomfort has resolved. Your doctor will advise you on how quickly you can resume normal and more vigorous activity. Please ask your doctor for his/her opinion and ask them to complete a “fitness to work” certificate for you to take to your employer. If you have not told your employer the reason for your absence and you do not wish for them to know we will respect your confidentiality and will discuss with you what you wish writing on the certificate.
Special measures after the procedure:

**Vaginal bleeding:** You may also experience some vaginal bleeding/discharge that may last up to two weeks. In some women increased discharge may persist up to one year after the procedure. Please wear sanitary towels/panty liners and not use tampons during this time and avoid sexual intercourse whilst you have the bleeding / discharge. These measures will help to prevent any infection. If the fibroid dies as a result of the treatment it may be expelled by the uterus. This can happen from between six weeks and three months after the procedure. This may cause you some abdominal discomfort.

**Pain:** At home you may experience crampy abdominal for up to 30 days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this.

**Puncture site(s):** You should keep the puncture site(s) clean and dry. There may be some initial oozing at the site but this will settle. We advise you to shower only and drying with a clean face flannel (to save washing towels) - avoiding long soaks in the bath or swimming until the wounds are fully healed. The site may be tender for a few days and a lump may appear which can last for up to six weeks.

**Hygiene:** As previously mentioned please use sanitary towels and do not use tampons. You are able to shower or bath following the procedure but do not have the water temperature too hot as this may make you feel faint and dizzy.

**Menstruation:** It may take between six to nine months to resume regular menstruation.

**Sexual intercourse:** We advise that you avoid sexual intercourse if you have any vaginal bleeding or discharge. Once your menstrual cycle resumes you may be able to become pregnant. We suggest you discuss contraception with your GP.

**Pelvic Floor Exercises:** It is never too late to start pelvic floor exercises, these will help to reduce the possibility of pelvic floor prolapse.

**When to seek advice (RED FLAGS):**

You should see your GP or contact us on the numbers listed below if you develop any of the following:

- Have an offensive vaginal discharge
- A fever
- Increasing pain
- Experience nausea and vomiting
- Pain that is not controlled by over the counter (OTC) medications
- If the area around your wound(s) becomes red, hot to touch or more painful than before
Check-ups and results: Before you leave hospital, you will be given details of if and 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

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

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


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

Serious risks (risks that are important and may affect your overall health)

- Post-embolisation syndrome (nausea, vomiting and/or temperature following the procedure): very common, occurs in up to 9 in 10 women. Post-embolisation syndrome is usually self-limiting and can be managed with analgesia and anti-inflammatory medicines, such as paracetamol. Up to 5 in 100 women will require readmission to hospital with post-embolisation syndrome.

- Passing the fibroid through the vagina: common, occurs in up to 1 in 10 women. In most cases the fibroid is able to pass through the vagina but an operation may be needed in up to 6 in 100 women. This complication is more likely if you have a submucous fibroid (in the cavity of the uterus) but we try to exclude that possibility with the MRI imaging before the procedure. It may be accompanied by pain and increased vaginal discharge.

- Amenorrhoea (periods stopping due to interruption of the blood supply which supplies the ovaries): common, occurs in up to 1-8 in 100 women. The risk is higher in women over the age of 45 (25 in 100 women).

- Failure to improve symptoms necessitating further treatment, including repeat embolisation or hysterectomy: very common, occurs in up to 35 in 100 women in the long-term (10 years after the procedure).

- Serious uterine infection leading to sepsis (infection in the bloodstream) necessitating urgent hysterectomy: uncommon, occurs in up to 1 in 100 women. Severe sepsis with organ failure is rare. Most infections can be treated successfully with antibiotics.
Successful pregnancy is possible following uterine artery embolisation, but there may be a higher risk of miscarriage, preterm labour and needing a caesarean section. It is important to discuss your plans for future pregnancies with the gynaecologist as other treatments may be more suitable.

Deep vein thrombosis (a clot in the leg veins) and pulmonary embolism (a clot in the lungs) these are uncommon (up to 1 in 400) and death from pulmonary embolism is very rare. The TED stockings will reduce the risk and if you have other risk factors we may give an injection (Dalteparin) which helps to prevent blood clots.

Allergic reaction to the contrast medium or embolisation material- common, up to 3 in 100 women. This is usually a rash which can be managed with antihistamines. A serious anaphylactic reaction is rare (up to 1 in 1000).

Arterial dissection or perforation- rare, 2 in 1387 women. This may be associated with bleeding requiring an operation or blood transfusion (see above).

Femoral artery occlusion- rare, 1 in 1387 women.

Bowel perforation- rare, 1 in 1387 women.

Death- very rare, fewer than 10 cases have been reported in the scientific literature worldwide.

Frequent risks

Some pain is expected after the procedure and up to 1 in 10 women will have pain up to 30 days after the procedure.

Vaginal discharge- vaginal discharge is very common up to two weeks after the procedure (occurs in up to 3 in 10 women). It may be brown in colour. In some women increased discharge may persist up to one year after the procedure (up to 2 in 100 women). If the discharge becomes malodorous or you experience pain with discharge you should seek medical help.

Mild uterine infection- uncommon, occurs in up to 1 in 100 women.

Urinary tract infection- uncommon, occurs in up to 1 in 100 women.

Urinary retention requiring catheterisation- uncommon, occurs in up to 1 in 200 women.

Groin haematoma (bruising with swelling) where the incision is made- common, occurs in up to 2 in 100 women. Occasionally the incision site can become infected and needs treatment with antibiotics.

Missed/ irregular periods is common (up to 7 in 100 women) and may last one year.

Adverse change in sexual function- common (up to 1 in 10 women). Some women may find they are less interested in sex, due to pain or vaginal discharge. However, for 9 in 10 women there is no change or an improvement.
Alternative procedures that are available

Uterine artery embolisation is not the only option for treatment of symptomatic fibroids.

- Medication- hormonal treatments (tablets, injections or the Mirena coil) can be used for some women with fibroids. We recommend you discuss this option with your Gynaecologist.
- Hysterectomy- removal of the uterus is a permanent solution for fibroids, but it is an operation requiring general anaesthetic and may be associated with more short-term and long term complications. It would not be an option if you wanted to maintain fertility.
- Myomectomy- removal of the fibroids either through the cervix or in incision in the abdomen (depending on the type of fibroid) is another option, but may be associated with more short-term complications. Myomectomy may be more suitable if you are planning on becoming pregnant. If this is the case we recommend you discuss this with your Gynaecologist.

An alternative to this procedure is a decision not to have the procedure or any other treatment. We will discuss with you the implications of deciding not to have the procedure.

Information and support

Please ask us for further information on uterine artery embolisation. The following contacts may be able to provide advice:

- Clinic 24 (The Emergency Gynaecology Unit and Early Pregnancy Unit)
  Telephone: 01223 217636
  Open 08:00 – 20:00 Monday to Friday
  08:30 – 14:00 at weekends
  Closed Bank holidays
- Daphne Ward - Inpatient Gynaecology ward
  Telephone: 01223 257206
  At all other times
- Radiology Administrator
  01223 348920
  09.00 – 17.00 Monday to Friday

Further information

The following websites and leaflets may also be helpful:

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. Generally you will have:

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 procedure you have had, how much pain relieving medicine you need and your general health. Most people will have pain after their procedure. Some people may feel dizzy, sick or have general aches and pains.

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](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1  **Creutzfeldt Jakob Disease (‘CJD’)**

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2  **Photography, Audio or Visual Recordings**

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment; they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to take photographs or to use any images or recordings in publications or research.

3  **Students in training**

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4  **Use of Tissue**

As a leading biomedical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on **01223 216756**.

Privacy & dignity

PSCF Uterine Artery Embolisation, CF462, Version number 3, December 2018
Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

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

Other formats:
If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 348043, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.information@addenbrookes.nhs.uk.

Document history
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Uterine artery embolisation

To relieve symptoms (pressure, painful periods, heavy periods, pain during sexual intercourse) from uterine fibroids

Post-embolisation syndrome (pain, nausea and/or vomiting after the procedure), passing the fibroid through the vagina after the procedure, vaginal discharge, amenorrhoea (periods stopping), missed or irregular periods, failure to improve symptoms or the symptoms coming back necessitating another procedure in the future, groin haematoma, sexual dysfunction, blood clots in the legs or lungs, infection (in rare cases infection leading to sepsis), urinary retention requiring bladder catheterisation, allergic reaction to contrast media used, arterial dissection, bowel perforation, death.

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Uterine artery embolisation

1. Any extra procedures that might become necessary during the procedure such as:
   - Blood transfusion
   - Other procedure (please state)

2. The following information leaflet has been provided:
   Patient information and consent to Uterine Artery Embolisation
   Version, reference and date: Version 2, reference CF462, date October 2018
   or ☐ I have offered the patient information about the procedure but this has been declined.

3. This procedure will involve:
   - General and/or regional anaesthesia
   - Local anaesthesia
   - Sedation
   - None

   Signed (Health professional): __________________________ Date: D D / M M / Y Y Y 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

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PSCF Uterine Artery Embolisation, CF462, Version number 3, December 2018
Consent Form

Uterine artery embolisation

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:

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Consent Form

Uterine artery embolisation

**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: ..................................................

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

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