Patient information and consent to interval cytoreductive surgery for ovarian cancer

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

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

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you 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 after surgery. Simple bowel medication such as senna and lactulose may be required after surgery. 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. Do not take any medications used to treat diabetes.

- Please call the surgical care practitioner on telephone 01223 216251- Pager: 1562074 or the lead nurse gynaecological oncology on telephone number 01223 586892 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). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health.
However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

About interval cyto-reductive surgery

Interval cyto-reductive surgery has been recommended as part of your treatment for ovarian (or ovarian-like i.e. fallopian tube or primary peritoneal cancer) cancer. The aim is to remove as much of the remaining tumour as possible.

The aim of cyto-reductive surgery is to remove as much visible tumour as possible from your abdomen and pelvis. This surgery may involve a total hysterectomy (removal of the uterus and cervix, unless you have already had a hysterectomy) and a bilateral salpingoophorectomy (removal of both tubes and ovaries). We shall also remove the omentum (an apron-like fold of fatty tissue that hangs down from the stomach and covers the abdominal organs in the lower abdominal area) and possibly the appendix, and part of the peritoneum (the inner lining of the abdomen/tummy). These are all common sites for spread of the cancer.

On a small number of occasions (less than 1 in 10), we shall also need to remove a piece of affected bowel. We usually aim to join up the bowel within your abdomen if at all possible, but might need to form a stoma (an opening on the abdominal wall) to allow the passage of faeces. If you have a stoma there is a 60% chance that you might have it reversed at another operation at a later date, depending on the disease response to chemotherapy. In addition, we may remove some of the lymph nodes in the pelvis or next to the large blood vessels in the abdomen (pelvic and para-aortic lymph node sampling). In a small number of cases we may also recommend removal of other organs including the spleen and gallbladder. If you have your spleen removed you will be more susceptible to get infections in the future, and therefore we will recommend that you have a set of vaccinations to prevent such problems.

Usually, you will have chemotherapy shortly after you have recovered from surgery.

The exact procedure that is carried out will depend on your particular circumstances, including your general fitness and health, the nature of your current condition, and your previous surgical history. All patients in whom cyto-reductive surgery is recommended will also have their case discussed by a group of specialists in the multi-disciplinary team meeting, which will also include a review of your recent blood tests and scans. Your medical team will discuss with you the exact details of your planned surgery in the outpatient clinic before you operation. Decisions about treatment and care are best when they are made together. You will have the opportunity to talk with your surgeon about your options, and to share your views and concerns.
**Intended benefits**

We aim to remove all remaining ovarian or ovarian-like tumour visible or as much as possible.

**Who will perform my procedure?**

A consultant gynaecological oncologist or a subspecialty senior trainee in gynaecological oncology (working under supervision) will perform this procedure. In some cases we work with surgeons from other specialities, where their expertise is needed.

**Before your procedure**

Most patients attend a pre-admission clinic, when you will meet the pre-admission sisters and usually you will see one of the consultant gynaecological oncologists. We will have discussed your case in our weekly multidisciplinary meeting and decided that offering you surgery will be, on balance, beneficial for your future care. You should be able to meet the gynaecological oncologist who will be performing your surgery prior to the surgery date.

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 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. If you are taking aspirin then we usually ask you to stop taking these two weeks before surgery. This also applies to the non-steroidal anti-inflammatory drugs (NSAIDs) class of drugs such as Nurofen (ibuprofen). If you are taking anticoagulant drugs such as heparin-type injections, warfarin or clopidogrel, then please tell the pre-admission sister as we shall organise appropriate anticoagulation cover for you during and after your operation.

We will ask whether you have any allergies. It is important that you tell us about any bad reactions that you have had with medication or operations prior to surgery.

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 three to five days after surgery. Usually you will be admitted to the hospital on the day of surgery. Using the enhanced recovery principles, you may be given pre-operative drinks to help with your hospital stay (see enhanced recovery leaflet).

We will give you medication to reduce the likelihood of infection and blood clots and a combination of drugs to reduce post-operative infections.
During the procedure

In some cases your surgeon may first recommend that you have a laparoscopic (key-hole) assessment to make sure that all or most of the tumour could be removed with an open operation, before making the cut for the definitive operation. If this is the case your surgeon will discuss this with you prior to your planned surgery.

The incision (cut) for the open operation is of the midline ('up and down') type, and usually runs from the bottom of your abdomen to some way above your tummy button. The exact length of your incision will depend upon your individual circumstances. A catheter is also placed in the bladder to allow accurate measurement of the urine that you produce. In some cases a nasogastric tube will be placed down your nose when you are asleep. This keeps the stomach empty of food etc and is usually removed before you wake up. Sometimes a fine tube is placed in a vein in the side of your neck (a central line). Occasionally, a fine tube is placed in an artery in the wrist (arterial line). These help the anaesthetist during surgery and your team after surgery to monitor your wellbeing. A dissolvable suture and tissue glue are used to close the skin wounds at the end of the operation.

During surgery, you will lose some blood. If you lose a considerable amount of blood, or if you are anaemic at the start of your operation, your doctor may recommend replacement 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 completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.
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.

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.

**Eating and drinking.** Usually following surgery you will be able to drink small amounts of water (30-60 mls an hour, about half a cup). As you recover, other fluids and food will be introduced until you return to your normal diet. Eating and drinking helps your recovery and therefore we will encourage you to drink fluids and eat light foods as you please. Sometimes we offer you dietary supplements to improve your wellbeing. Sometimes, you might need feeding through a tube down your nose or through your veins, until you are able to tolerate reasonable amounts of food orally.

**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. If you have an epidural, you will find that you might not be as mobile at first. When the epidural is removed and the effects wear off, we will encourage you to be active for your own wellbeing. You would have access to physiotherapy support with your breathing and mobilising.

**Leaving hospital.** The time that you stay in hospital will depend on how quickly you recover from your operation and the extent of operation you have had. If you have problems with the operation or require further treatment you might need to stay in for longer. Typically, we suggest you may leave hospital as early as three days after surgery, although many patients will require a longer stay. You are ready to leave hospital when you are mobile, controlling your pain with oral medication, passing urine and flatus (wind). We often give you a laxative to help with your bowel motion but we do not need to keep you in hospital to see your bowels working.

**Resuming normal activities including work.** You can usually resume normal activities including beginning gentle work within two to four weeks of your operation. Often you will want to wait a little longer before resuming more vigorous activity. Driving is possible from four weeks after surgery.
Special measures after the procedure. We usually advise a gentle return to your normal function at four to six weeks after the operation. No special diet or exercise is required.

Check-ups and results. We will give you information about the results of your surgery as soon as possible after the operation. Usually you will have an oncology clinic appointment to plan chemotherapy for your cancer. Please do not hesitate to ask questions to any of the staff treating you. They can also help you contact your surgeons if necessary.

Preventing complications from blood clots (venous thromboembolism). Major surgery is known to increase the risk of blood clots forming in the veins (often in the leg or pelvis) and this is known as a deep vein thrombosis (DVT). If a piece of this blood clot gets dislodged it can travel to the lungs and cause a blockage known as a pulmonary embolism (PE). This complication can be life-threatening. We therefore recommend steps to minimise this risk. This usually includes the use of compression stockings (TED stockings) and blood thinning medications. In most cases we recommend that these preventative measures are continued for a month after surgery.

Significant, unavoidable or frequently occurring risks of this procedure
All surgery is associated with risks of complications, and we take steps to keep these risks to a minimum. The risks will also depend upon the procedures that are carried out during your surgery, and your surgeon will discuss these with you prior to your operation.

- Damage during the surgery to the bowel or to the urinary tract (including the bladder or ureters).
- Haemorrhage (bleeding) during or after the surgery.
- Infection (including of the chest, wound, line, bladder, blood).
- Thrombosis (including pulmonary embolus).
- Problems at the wound openings/scars (including hernia).
- Problems related to bowel surgery including leakage from bowel join (rare) and the stoma
- Problems related to peritoneal surgery. If the peritoneum over the diaphragm is removed there is a small chance of chest or breathing problems (such as leakage of air into the chest, or a fluid collection in the chest).
- Return to theatre for emergency surgery. A small minority of complications may require further surgery
- There is a tiny risk of death. At Cambridge University Hospitals, this is less than 1 per 100. You will be cared for by a skilled team of doctors, nurses and other health care workers who are involved in this type of surgery on a daily basis. Any problems that arise can be rapidly assessed and appropriate action taken.
Alternative procedures that are available

The main alternative to this surgery is to decide not to have surgery, and / or to begin or continue with chemotherapy. Please discuss this with your surgeon – in general we think you are more likely to have a successful recovery if you undergo this surgery.

Information and support

We may give you some additional patient information before or after the procedure, such as 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Operating Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Nurse Gynaecological Oncology</td>
<td>01223 586892 (internal ext 6892)</td>
<td>Monday to Friday 08:00 to 16:00 hours</td>
</tr>
<tr>
<td>Surgical Care Practitioner</td>
<td>01223 216251 Pager:1562074</td>
<td></td>
</tr>
<tr>
<td>Pre admissions reception</td>
<td>01223 256584</td>
<td>Monday to Friday 09:00 to 17:00 hours (out of hours please leave a message on the answer machine).</td>
</tr>
<tr>
<td>Gynaecological Oncology Co-ordinators</td>
<td>01223 216251/348203</td>
<td>Monday to Thursday 09:00 to 17:00, Friday 09:00 to 16:00 hours</td>
</tr>
</tbody>
</table>

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.
Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medication**
You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

**Moving to the operating room or theatre**
You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**
During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**
Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. **Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.**
Local anaesthesia

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted and 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, 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
Patient Information

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 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.
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
Authors Gynaecology Department
Pharmacist Ebraheem Junaid
Department Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
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Version number/Ref 8/CF240/1813

Interval cyto-reductive surgery for ovarian cancer, CF240, V8, June 2018
Patient Information

Interval cyto-reductive surgery for ovarian cancer, CF240, V8, June 2018

Consultant or other responsible health professional

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 intended benefits of the procedure to remove all or most of the remaining visible ovarian or ovarian-like tumour as possible.

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:
   • damage to bowel, bladder, tubes from kidneys to bladder
   • wound infection/breakdown/scarring
   • blood clots (legs and/or lungs)
   • excessive bleeding.

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

Interval cyto-reductive surgery for ovarian cancer

d) any extra procedures that might become necessary during the procedure such as:

☐ Blood transfusion  ☐ Other procedure (please state)

2 The following information leaflet has been provided:
Interval cyto-reductive surgery for advanced ovarian cancer

Version, reference and date: CF240, version 8, June 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: __/__/YYYY

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

Interval cyto-reductive surgery for ovarian cancer

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: ____________________________
Consent Form

Interval cyto-reductive surgery for ovarian cancer

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: ..........................................................

Patient safety – at the heart of all we do

Interval debulking surgery for ovarian cancer, CF240, V8, June 2018