Patient information and consent to Surgical removal of acoustic neuroma

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.

- Laxatives and painkillers may be required after your hospital stay; please ensure you have appropriate supplies at home.

- 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 clinical nurse practitioner on telephone number 01223 245151 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.

Surgical removal of acoustic neuroma, CF083/1837, Version 4, December 2016
About surgical removal of acoustic neuroma

Usually the first symptom of an acoustic neuroma is when you lose some or all of the hearing in one ear. However, the tumour actually arises from one of the nerves of balance. Typically, growth is slow and almost invariably the tumour is benign (not cancer). However, without treatment, it can enlarge progressively to compress the brainstem to damage other nerves and block the spinal fluid pathways. Eventually it could cause serious neurodisability or even death.

Intended benefits

The aim of surgery is to remove the tumour completely. However if the capsule of the tumour is very adherent to the facial nerve or brainstem, a small remnant may be left attached, if removal of it is likely to cause nerve damage.

Who will perform my procedure?

This operation will be performed jointly by a Neurosurgeon and an Otologist.

Before your procedure

Most patients attend a pre-admission clinic, when you will meet the specialist nurse practitioner. 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. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries. If you are taking Aspirin then you must stop taking it 10 days before 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 approximately five to seven days. Sometimes we can predict whether you will need to stay for longer than usual - your doctor will discuss this with you before you decide to have the operation.
During the Surgical removal of acoustic neuroma

- This operation involves the use of general anaesthesia. See page seven for further details about the types of anaesthesia we shall use.
- Surgery is one of three options for the management of acoustic neuromas. Other options are ‘wait and watch’ and radiosurgery (see the section on alternative treatments). Complete removal of the tumour at surgery is achievable in 99.6% of cases and only 1% of tumours will start growing again. In patients who have small tumours and socially useful hearing (ie you can use the telephone), an attempt can be made to preserve the remaining hearing on the affected side; however, only around one in three of these patients will have any hearing at all in that ear after the operation. In patients who have larger tumours, or those who have no socially useful hearing, it can be assumed that hearing will be permanently lost on that side after surgery.
- Your surgeon will discuss with you whether it is possible to attempt to save some hearing on the affected side. This affects the technical details of the operation and how we reach the area:
  - A hearing-preservation operation is described as a retro-sigmoid approach.
  - Most non-hearing preservation operations are carried out via a translabyrinthine approach.
- For both operations, we make an incision behind the ear and remove a small amount of bone to give us access to the tumour. When we close the wound, we remove a small piece of tissue from the outer thigh (usually the right side) to seal up the bone of the ear. This is necessary to reduce the risk of cerebrospinal fluid (one of the fluids surrounding the brain) getting into the ear and then draining out through the nose via the small tube that connects the two.
- Occasionally, a small amount of the capsule (covering of the tumour) will be left in place if it is attached to important structures, for example the facial nerve. This decision will be made if there is concern that removing all of the capsule will cause nerve damage. Surgery cannot restore function in nerves that have already been damaged or destroyed by the tumour.

After the Surgical removal of acoustic neuroma

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 this operation, most people will have a small, plastic tube in one of the veins of their arm. This might be attached to a bag of fluid, called a drip, which feeds your body with fluid until you are well enough to eat and drink by yourself. You will also have a urinary catheter and thigh drain.
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.**

**Eating and drinking.** After this procedure, you can eat and drink when you feel ready, which is usually 24 hours after surgery.

**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 any mobility problems, we can arrange nursing or physiotherapy help.

**Leaving hospital.** Generally most people who have had this operation will be able to leave hospital after seven days. 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. We advise you to have someone at home with you for two weeks after you are discharged.

**Resuming normal activities including work.** Usually you can resume normal activities after approximately eight to twelve weeks. You should not return to work until you have been reviewed in the outpatients clinic, which will be approximately six weeks after surgery. Your doctor will advise you on how quickly you can resume normal and more vigorous activity.

**Special measures after the procedure:** You are advised not to drive until you have been reviewed in the outpatients clinic and must not fly for three months after surgery. We will give you further information about any special measures you need to take after the procedure. We will also give you information about things to watch out for that might be early signs of problems (eg infection).

**Check-ups and results:** Before you leave hospital, we will give you an appointment for an outpatient clinic or for the results of your surgery to be reviewed by the neurosurgeon about six weeks after surgery. At this time, we can check your progress and discuss any further treatment. If tests are required, please include how the patient will receive their test results and when to expect them. You will also be asked to attend an appointment to see the ENT surgeon 12 weeks after surgery.
Significant, unavoidable or frequently occurring risks of this procedure

The risks of any surgical operation:

- **Haemorrhage** (1%). Although the risk of bleeding is very small, when it occurs in a confined space, for example next to the brainstem, it can result in serious permanent neurological disability. This can include limb weakness or paralysis, difficulty in breathing or impaired swallowing.

- **Respiratory complications** - chest infections which can usually be treated with antibiotics.

- **Blood clots** - there is a risk of deep-vein thrombosis in the legs, which occasionally pass to the lungs (pulmonary embolism).

- **Wound problems** including wound infection or leakage.

- **Heart** for example, abnormal rhythm or heart attack.

- **Death** (less than 1%).

The risks specifically related to the surgical removal of acoustic neuromas:

- **Facial weakness**: The facial nerve (which is a nerve that supplies the muscles of facial expression), and the acoustic nerve (the nerve of hearing and balance) run very close together. Due to their anatomical position, the facial nerve is always attached to the surface of the tumour and is at risk during tumour removal. The risk of facial weakness after this operation depends on the size of the tumour and how tightly it is stuck to the facial nerve.

  - With small tumours, it is nearly always possible to preserve the facial nerve anatomically (ie not seen to damage it ‘by eye’), but the facial muscles may be weak for a number of months afterwards.

  - With some larger tumours, and even very occasionally small tumours, it is not possible to spare the facial nerve. If the facial nerve is completely lost, or fails to recover after the operation, there are a number of plastic surgical operations that can be undertaken to restore some function (your doctor can discuss this with you).

- **Hearing loss**: Most acoustic neuromas are diagnosed after the patient experiences a loss of hearing, which can be partial or total. Following surgery, the majority of patients will lose their hearing completely in the affected ear. We will review your hearing tests and look at the appearance of the tumour on the scan. With this information, we can advise you as to whether an attempt can be made to preserve your remaining hearing in that ear. This will be discussed in detail with you before the operation.

- **Tinnitus**: Some patients experience tinnitus (for example ringing noise) in the affected ear. Even when hearing is lost completely after surgery, it is possible that you will still have tinnitus.
Even if you had no tinnitus before the operation, it may develop afterwards. However, it is unusual for tinnitus to be dramatically worse after an operation.

- **Cerebral spinal fluid (CSF) leak:** CSF bathes the brain in fluid. When the tumour is removed, the cerebro-spinal fluid pathways around the brain are opened. CSF can leak out either through the entry wound or into the ear and then down the nose. The risk of this leakage is around 4%. If a drainage tube is placed temporarily in the spinal fluid pathways in your back, the majority of leaks will settle down, but around one in three leaks will require a second operation to repair them.

- **Infection:** The surgical removal of acoustic neuroma is long, and the ear can contain germs that can get inside the head. These can infect the cerebro-spinal fluid and cause either a local wound infection or meningitis. If there is leakage of cerebro-spinal fluid after surgery (see above) this can cause infection. The diagnosis is made from lumbar puncture. The majority of infections can be treated satisfactorily with antibiotics. Very occasionally, there can be serious and long-standing problems from infection inside the head. Your doctor can discuss this with you on request.

- **Problems with balance:** Although this type of tumour is called an acoustic neuroma, they usually arise from the nerve of balance. In many cases, the nerve will have been slowly destroyed by tumour growth. This allows your brain to compensate for the reduction in information it receives about balance by relying on the other ear. The tumour can only be removed by cutting through the nerve of balance in the affected ear. Therefore, if before the operation there was some function in the nerve, you will feel dizzy and unsteady after the operation, until your brain gets used to it. Your balance may be tested before the operation; your surgeon will discuss with you the likelihood of you being unsteady or dizzy after surgery.

In addition, we will need to temporarily displace the cerebellum (the balance part of your brain). There is a very small risk that this part of your brain could be injured during removal of the tumour which might result in permanent unsteadiness.

- **Difficulty swallowing:** In large tumours (generally those more than 3cm), the nerves that control swallowing and supply the vocal cords might be stuck to the tumour. If this is the case, these nerves might not function after the tumour has been removed. This can result in difficulty in swallowing and hoarseness of the voice for a number of months after surgery. Very occasionally, problems of this kind are permanent.

- **Stroke/major neurological impairment:** There is a very small (around 1 %) risk of major neurological impairment following surgery. The greatest risk is if there is any bleeding into the cerebellum or around the brainstem after surgery. A further small risk is of bleeding from the important blood vessels supplying the brainstem and cerebellum, which can become quite stuck to the tumour, particularly if it is of a large size.
- **Headache and neck pain:** So we can gain access to the bone behind the ear during surgery, we need to disturb some of the neck muscles in this area. This will cause some neck pain and stiffness. It is common to experience headache after operations on the head, particularly for the first few days. This will be controlled with painkilling medication, and occasionally by repeated lumbar puncture.

- **Numbness of the facial skin:** With large acoustic neuromas, the trigeminal nerve (the nerve of feeling to the face) can also become stuck to the tumour. If this nerve is damaged during the operation, you can experience numbness in that side of the face. Our greatest concern here is if the surface of the eye becomes numb. If grit or dirt gets into the eye you might not be able to feel it, which can lead to damage and later infection. If you have facial numbness, particularly in combination with facial weakness, you will need to take particular care to ensure that your eye is protected. If this is necessary, you will be taught how to do this.

General risks associated with all major operations and from being hospitalised: eg bleeding, infection, blood clots.

### Alternative procedures that are available

- Interval scanning (‘wait and watch policy’): As acoustic neuromas often grow very slowly (the average growth rate is around 2 mm per year), small tumours can be monitored by a period of observation. Generally, this is only suitable in the longer term for small tumours (those that are less than around 1.5 cm).

- **Stereotactic radiosurgery:** Radiosurgery is an alternative to surgical removal but is not generally suitable for large tumours (greater than about three cm in diameter). In this operation, the tumour is not removed but gamma radiation, a high-energy type of X-ray, is used to try and prevent further growth. The two methods of carrying out this treatment are:
  - **Gamma knife** – You would receive a single dose of gamma radiation using multiple radiation beams that are focused on the tumour. This treatment is currently available in Sheffield and London.
  - **Linear acceleration (LINAC)** – Radiation is given as a series of fractions rather than as a single dose. This treatment is currently available in Cambridge.

The main advantages of radiosurgery are that it avoids the risks of a surgical operation (see page five). You will recover from the operation quickly. In the short term at least, any remaining hearing in the affected ear is likely to be preserved as is the facial nerve function.

The disadvantages of radiosurgery are that the tumour is not removed, and the treatment does not always prevent the tumour from continuing to grow.

Radiosurgery can also make any following surgery on this area technically more difficult.
• Having radiosurgery before surgical removal does not significantly change the risks of damage to the facial nerve. There is however, a theoretical risk that using radiation during radiosurgery could stimulate the growth of a malignant (cancerous) tumour at a later date. However, the risk of this is extremely small (there have been no more than a handful of cases reported world-wide despite more than 20,000 patients receiving this treatment).

An alternative to this surgery is a decision not to have surgery. We will discuss with you the implications of deciding not to have surgery.

Information and support
For any emergency - see your GP or your local Accident and Emergency department.

For advice contact your consultant’s nurse specialist – via Addenbrooke’s switchboard.
For advice on appointments – contact your consultant’s secretary - via Addenbrooke’s switchboard.

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.

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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.

It is common practice nowadays to allow a parent into the anaesthetic room with children; as the child goes unconscious, the parent will be asked to leave.

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.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.
Very common (1 in 10 people) and common side effects (1 in 100 people)
Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

Uncommon side effects and complications (1 in 1000 people)
Chest infection
Muscle pains
Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)

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

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

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: www.rcoa.ac.uk
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 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

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

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

Other formats:

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk.
Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

Document history
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Surgical removal of acoustic neuroma

Consent Form
Patient agreement to investigation or treatment for neurosurgery, spinal surgery or vitreoretinal surgery

Please use ‘Procedure completed’ stamp below on completion:

Interpreter’s statement (if appropriate)
I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): ............................................................... Date: ........................................

Name (PRINT): ........................................................................

Or, please note the language line reference ID number:

Cambridge University Hospitals NHS Foundation Trust

Addenbrooke’s Hospital | Rosie Hospital


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Surgical removal of acoustic neuroma

Haemorrhage, Respiratory complications, Blood clots, Wound problems, Heart Death, Facial weakness, Hearing loss, Tinnitus, Cerebral spinal fluid (CSF) leak, Infection, Problems with balance, Difficulty swallowing, Stroke/major neurological impairment, Headache and neck pain and Numbness of the facial skin

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

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

Blood transfusion
Other procedure (please state)

Surgical removal of acoustic neuroma

The following information leaflet has been provided:

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

This procedure will involve:

General and/or regional anaesthesia
Local anaesthesia
Sedation
None

Signed (Health professional): ........................................... Date: DD/MM/YYYY

Name (PRINT): ......................................................... Time (24hr): H H : M M

Designation: ............................................................. Contact/bleep no: ........................................
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 on 'Consent' and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
   a) 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
   
   b) Have you had a history of CJD or other prion disease in your family? □ Yes □ No
   
   c) Have you ever received growth hormone or gonadotrophin treatment?
      If yes, please give details below:
      Please specify:
      (i) whether the hormone was derived from human pituitary glands □ Yes □ No
      
      (ii) the year of treatment
      
      (iii) whether the treatment was received in the UK or another country □ UK □ Other
   
   d) Have you ever had surgery on your brain, eye or spinal cord?
      If yes, please give details below:
   
   e) Since 1980, have you had any transfusions of blood or blood components (red cells, plasma, cryoprecipitate or platelets)?
      If yes, please answer questions below:
      Have you either:
      (i) received more than 50 units of blood or blood components, □ Yes □ No
      or
      (ii) received blood or blood components on more than 20 occasions □ Yes □ No
      
      Where possible, please provide the names of all the hospitals where you received blood or blood components:

In the case of a positive reply to any CJD question, staff should immediately inform Infection Control on ext 3497 (bleep numbers 152-198 or 151-803) and the theatre co-ordinator (24 hour bleep number 152-585); out of hours contact the on call medical microbiologist via the hospital contact centre.

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 Medical Training
   I agree to the involvement of medical and other students as part of their formal training. □ Yes □ No

Please turn over
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 entitled Consent and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ___________________________ Date: _____D.P./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.P./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.P./M.M./Y.Y.Y.Y____

Name of witness (PRINT): ___________________________

Address: ___________________________

Confirmation of consent

Confirmation of consent (where the procedure/treatment 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.P./M.M./Y.Y.Y.Y____

Name (PRINT): ___________________________ Job title: ___________________________

Please initial to confirm all sections have been completed:

Withdrawal of patient consent

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

Signed (Patient): ___________________________ Date: _____D.P./M.M./Y.Y.Y.Y____

Signed (Health professional): ___________________________ Date: _____D.P./M.M./Y.Y.Y.Y____

Name (PRINT): ___________________________ Job title: ___________________________