Addressograph label

Patient agreement to treatment

Please bring this form on each visit to the hospital.
You will be asked to read this form carefully and you and your doctor (or other appropriate health professional) will sign the document confirming your consent to the procedure.

For staff use only: Does the patient have any special requirements?

☐ An interpreter ☐ Other communication method ☐ Other

.....

Important note: (tick if applicable) ☐ See also advance directive / living will (eg Jehovah's Witness form)

TO BE RETAINED IN PATIENT'S NOTES

Consent Form - Part A

Common Risks:
Incontinence of stools or flatus (wind).
Fear, difficulty and discomfort in passing stools in the immediate postnatal period
Migration of suture material requiring removal
Granulation tissue formation
Faecal urgency, 26/100 (very common)
Perineal pain and dyspareunia, 9/100 (common)
Wound infection, 8/100 (common)
Urinary infection.

Uncommon Risks:

● Delivery by caesarean section in future pregnancies may be recommended if symptoms of incontinence persist or investigations suggest abnormal anal sphincter structure or function.

Rare Complications:

● Haematoma.

● Consequences of failure of the repair requiring the need for further interventions in the future such as
secondary repair or sacral nerve stimulation.

Very rare complications:

● Rectovaginal fistula.

5. Any extra procedures which may become necessary during the procedure

● Blood transfusion. ● Rarely, a vaginal pack is required if haemostasis cannot be achieved.

The Intended Benefits: Repair of 3rd/4th degree perineal tear is to optimize the outcome and reduce the risks of bowel problems (the occasional loss of control of wind or of liquid stool, loss of control of bowel movement or the inability to postpone bowel movement for long)

> **NB:** The outlook following the repair of 3rd/4th degree perineal tears is generally good with over 80% of women having no symptoms whatsoever at 12 months. Some women will however have symptoms, most of which will resolve with Physiotherapy and only very few will need further intervention

I have asked the patient if she has any specific concerns.

☐ Blood transfusion ☐ Other procedure (please specify) _____

The following patient information leaflet has been provided:

Following a 3rd/4th Degree Perineal Tear **copy accepted by patient:**

☐ **Yes** ☐ **No (please tick)** ☐ **Yes** ☐ **No**

This procedure will involve: ☐ general and/or regional anaesthesia

Signed: _____Date:_____Name (PRINT): Doctor_____ Job Title: _____

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe she can understand. Signed: _____ Date: _____

Consent Form - Part B

REPAIR OF SUSPECTED 3RD/4TH DEGREE PERINEAL TEAR

Statement of patient

Please read this form carefully

Do ask if you have any further questions, we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor or health care professional. You may decline to be involved in the formal training of medical and other students. This will not affect your care and treatment.

Please tick boxes to indicate you have understood and agree to the statements below.

- ❑ **I agree** to the procedure or course of treatment described on this form.
- ❑ **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- ❑ **I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)
- ❑ **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

Patient's signature: _____ Date: _____

Name: (PRINT)

_____

Statement of interpreter (where appropriate)

Signature: _____ Date: _____

Name: (PRINT)_____

TO BE RETAINED IN PATIENT'S NOTES