b) the possible risks involved. I have discussed and listed below significant, unavoidable or frequently occuring risks including any risks that may be of specific concern to the patient:

_____

_____

_____

c) what the benefits and risks of alternative treatments that might be offered for this patient (including option of no treatment):

_____

_____

_____

d) any extra procedures that might become necessary during the procedure such as:
Blood transfusion ☐ or Other procedure (please state):

_____

2 The following patient information leaflet has been provided:

Version No.:

or I have offered the patient information about the procedure but this has been declined ☐
or no further written information ☐

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

Signed (Health professional): _____ Date: _____

Name (PRINT): _____ Time (24hr): _____

Designation: _____ Contact/bleep no: _____

C Consent of patient/person with parental responsibility

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**

Medical Training

I agree to the involvement of medical and other students as part of their formal training. **YES / NO**

Use of Tissue

a) **I agree** that tissue (including blood) removed as part of my routine care but not needed for my own diagnosis or treatment can be used and stored for BioResource which may include genetic analysis **YES / NO**
I have received the patient information sheet about the BioResource **YES / NO**

b) Where additional clinical information is needed for the purpose of ethically approved research, I agree that relevant sections of my medical record may be looked at and anonymised prior to release to researchers **YES / NO**

I have listed below any procedures that **I do not wish to be carried out without further discussion.**

_____

_____

_____

_____

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.

I have read and understood information given to me about the planned procedure.

I wish to proceed with the planned procedure.

I therefore give my consent to the procedure as described

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 signing for a patient who does not have capacity, I confirm I am the person with legal welfare power of attorney or the welfare guardian acting in the best interest for the patient named in this form.

Signed:_____ Date:_____

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:_____

D 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:_____

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:_____

Name(PRINT):_____

Or, please note the telephone interpreter ID number: _____

F Withdrawal of patient consent

The patient has withdrawn consent and does not wish to proceed with the treatment.
(ask patient to sign and date here)

Signed (Patient):_____ Date:_____

Signed (Health professional):_____ Date:_____

Name (PRINT): _____

Job title:_____

Version 2.0 Authorised: Dec 2019 Review: Dec 2022

NHS Lothian Consent Form

NHS Lothian

Patient Name _____ DOB _____ CHI _____

Attach Label

Consultant or health professional responsible for your care

Name and job title: _____

Any special needs of the patient? (e.g. help with communication?)

_____

A Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear)

Please circle: Patient's **LEFT** / **RIGHT** side or **N/A**

_____

_____

B Statement of health professional (details of treatment, risks and benefits)

1 With **appropriate knowledge of the proposed procedure**, I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure. (please state)

_____

_____

_____

_____