

Facial and body prosthetics

Information and consent for patients

PART I: INFORMATION

Introduction

You have been referred to discuss whether we can provide you with a custom-made facial or body prosthesis.

We will discuss treatment options with you, and you will have the opportunity to ask questions or express any concerns that you may have. After this discussion you may decide to proceed with the treatment or not, or you may want to think about it before going any further.

The procedure

In order to create a device for you, we will need to take impressions (moulds) or “white light” scans of your face and/or body, in the areas that the prosthesis is required. For example: for an artificial ear we will need to take an impression of your existing ear as well as the side that the prosthesis is to be fitted. Other areas may also be recorded to help us with modelling the prosthesis. We may ask for impressions or scans of a relative if needed.

When the impressions or scans are taken you will be fully awake, able to breathe and kept informed of what is happening. You should feel no pain, although the pulsing light source of the White Light Scanner can feel unusual. If we are taking conventional impressions you may experience an unusual sensation when the impression materials are placed on your face and/or body.

When the materials are removed you may experience a tugging or pulling sensation for a few moments. We will try our best to avoid removing any hair with the impression by using petroleum jelly (Vaseline).

Conventional impressions that involve the nose and mouth - Depending on where the impression materials have to be placed, you may only be able to breathe through either your nose or mouth, whilst the mould is taken.

Your procedure/treatment plan:

Possible complications and risks (including any risks that may be of specific concern to you):

Have you a history of any of the following?	
Heart defect, heart disease (e.g. rheumatic fever) or heart surgery	YES <input type="checkbox"/> NO <input type="checkbox"/>
High/low blood pressure	YES <input type="checkbox"/> NO <input type="checkbox"/>
Chest problems (including asthma)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>
Photosensitive Epilepsy, Fits or fainting attacks	YES <input type="checkbox"/> NO <input type="checkbox"/>
Hepatitis / HIV / Jaundice	YES <input type="checkbox"/> NO <input type="checkbox"/>
Bleeding problems or blood disorders (including haemophilia)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Joint or bone problems (arthritis, back pain, limited dexterity)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Skin conditions (eczema, psoriasis or ulcers)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Allergies and sensitivities (to medications or materials)	YES <input type="checkbox"/> NO <input type="checkbox"/>

If you have answered yes to any of the above, please give details below:

Do you smoke?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you taking any medications or inhalers?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please state the medication name and your reason for taking it:	

PART III: CERTIFICATE OF PATIENT CONSENT

Statement of the healthcare professional	
I have explained what the procedure is likely to involve and the benefits and risks of any available alternative treatments (including no treatment) and answered any concerns raised by the patient	
Healthcare professional's signature: Print name: _____	Date: _____ Job title: _____
Statement of interpreter (where appropriate)	
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe that she / he / they can understand	
Signature: Print name: _____ Or, please note the telephone interpreter identification number: _____	Date: _____
To the patient: 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 agree to the procedure as described above	
Patient's signature: Print name: _____	Date: _____
If the patient is unable to sign but has indicated his/her consent, a witness should sign below	
Signature (Witness) Print name: _____ Address: _____	Date: _____