



**CONSENT FORM
FOR
REMOVAL OF ACOUSTIC
NEUROMA**

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
have an **acoustic neuroma** on theside and that **surgical removal** is proposed:

This means removing a tumour growing immediately beside the eighth cranial nerve within the brain.

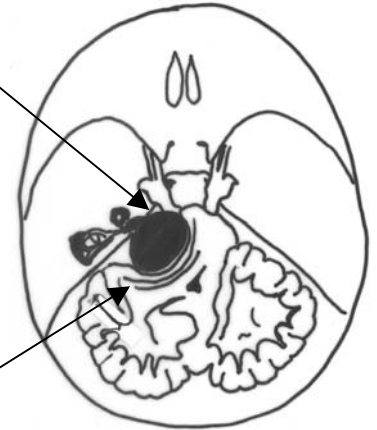
Under a general anaesthetic, a curved cut is made in the scalp, a small hole is drilled in the skull and a bone flap may be removed. The outer covering of the brain, (the dura) is then cut and the brain exposed. Tumour removal has two stages: de-bulking (ie removing as much as possible of) the central region of the tumour, followed by microscopic dissection of the tumour capsule away from adjacent brain, cranial nerves, and blood vessels.

When the operation has been completed, any bleeding is controlled, and the bone flap replaced and the wound is closed.

acoustic neuroma

INSIDE VIEW OF SKULL

compressed brain tissue



RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your ENT surgeon if you have any general or specific concerns.

I understand there are risks associated with any **anaesthetic** (see separate *Anaesthetic Consent Form*).

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation. Steroids may also be prescribed, which can cause reversible psychological changes including depression.

I understand the procedure has the following **specific risks and limitations**:

- The tumour may not be completely removable, increasing the chances that the disease may recur.
- Unavoidable damage to nearby nerves may result in difficulty with eating, drinking, blinking or facial expression, weakness of the vocal cord with voice changes, lost or altered taste. These may be treated using plastic surgery, nerve grafting or botox injections where necessary.
- I may have a dry eye or rarely may have double vision afterwards.
- Depending on the route used to get access to the tumour, my hearing may be reduced or destroyed completely on that side.
- I may develop problems with balance, which are usually temporary. I may have dizziness, vomiting, fatigue and unsteadiness. I may be unable to drive a car. Most cases respond well to rehabilitation, but in a few cases the symptoms may be permanent and disabling.
- I may have ringing in my ears (tinnitus)
- I may develop headaches, memory and concentration problems. I may feel I am 'not myself', and may be frustrated and intolerant. I may have some language difficulties. These are usually temporary and improve with time.
- I may develop a leak of the fluid from around the brain (CSF), which may require a further procedure.
- I may develop hydrocephalus, where CSF collects rather than circulating normally. This may require further treatment
- I may have a higher risk of meningitis (infection of the brain coverings), requiring antibiotic treatment
- I may have fits after the operation
- I may have a stroke
- There is a small chance of death, directly related to the operation.

RISKS CONTINUED OVERLEAF →

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RISKS CONTINUED

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my individual circumstances**, that I have considered in deciding to have this operation:

.....
.....
.....

DECLARATION BY PATIENT

- I acknowledge the ENT surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my ENT surgeon during this operation.
- I consent to a **blood transfusion**, if needed (*patient to circle and initial choice*) **YES** **NO**
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist ENT surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature of patient _____ **Date** _____

If the patient is an adult and unable to give consent, a proxy form must be completed and attached

DECLARATION BY DOCTOR

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature _____

Doctor's name _____ **Date** _____
(please print)

INTERPRETER'S DECLARATION - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature _____ **Date** _____

Interpreter's name _____
(please print)