



**CONSENT FORM  
FOR  
LARYNGECTOMY**

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

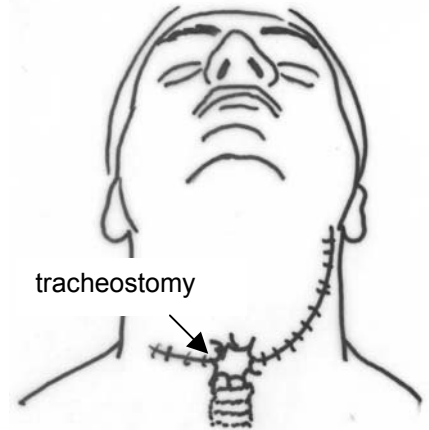
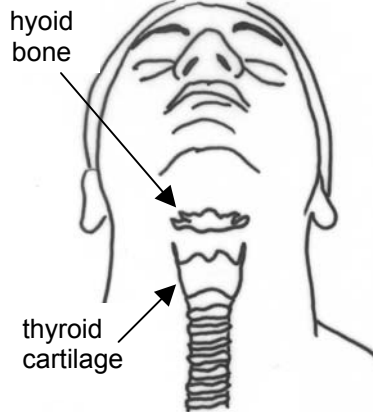
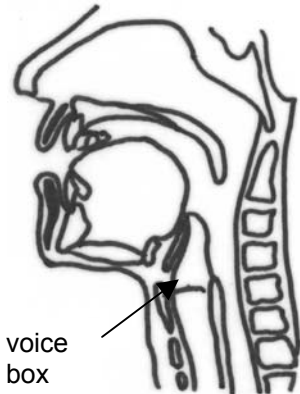
**PROPOSED TREATMENT**

The doctor has explained that I, (*name of patient*) .....  
have .....and that a **laryngectomy** is proposed:

**This means an operation to remove the voice box (larynx).**

**Under a general anaesthetic, a cut is made across the lower neck, which may curve up one side of the neck if the surgeon also plans to remove lymph nodes. Cutting the small muscles in front of the neck and removing part of the thyroid gland exposes the voice box. The hyoid bone above the larynx may be removed.**

**The windpipe is cut low in the neck and a tube is placed in the cut end. This is the new permanent tracheostomy. The voice box is separated from the gullet and can then be removed. The tissues are closed and an opening is made in the skin for the tracheostomy tube .**



**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.

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

- My wound may become infected, with redness, swelling and discharge. I may need antibiotics to treat this.
- I may have some bleeding from the operation site. Occasionally this may be serious and I may need a blood transfusion and/or I may have to go back to the operating theatre.
- Uncommonly, I may develop an opening (fistula) between the throat (pharynx) and the skin. This may be more likely if I have had radiotherapy before the operation. I may need surgery to help this heal.
- My tracheostomy may get narrower as the wound heals. This may make speech therapy or tracheostomy care difficult, and I need another operation.
- My tumour may come back at the edge of the operation site and may require further surgery.
- I may have some difficulty swallowing in future if the wounds heal with scarring. This may need further treatment.

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:

.....  
.....

**CONSENT FORM  
FOR  
LARYNGECTOMY**

Med Rec. No.....  
Surname:.....  
Forename: .....  
DOB:.....

AFFIX LABEL HERE

**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 ENT 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)*