



**CONSENT FORM  
FOR  
INCISION AND DRAINAGE OF  
PERIANAL ABSCESS**

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

**PROPOSED TREATMENT**

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

**This means opening an abscess near the anus to allow the pus to drain.**

**Under a general anaesthetic, a cut is made in the roof of the abscess and the pus drained. Small samples of the abscess wall and pus may be sent to the laboratory for examination to confirm the diagnosis.**

**The cavity of the abscess is washed out and any separate collections drained by gently probing the area. A small area of skin may be removed and/or the wound may be packed with a moist dressing to prevent the roof healing before the cavity has closed, risking a recurrence.**



**RISKS**

*These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your 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**:

- The abscess may recur and may require further surgery.
- I may develop a fistula-in-ano (a fine track between the lower bowel and the skin). This may require further surgery in the future before it heals. If a fistula has already occurred and is identified at the time it may be treated immediately. This may rarely cause problems with continence (control of the bowel)
- I may develop an infection in the blood (bacteraemia) with fever and chills and may require antibiotic treatment.
- I may have some difficulty starting to pass urine after the operation and may require a temporary urinary catheter.
- Rarely, if there is underlying disease, the wound may only heal very slowly, or may fail to heal. If this happens, I may need further tests and possibly treatment, depending on the results.
- Very rarely, the infection may spread to surrounding tissues, requiring intensive antibiotic 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:

.....  
.....

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**DECLARATION BY PATIENT**

- I acknowledge the 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 surgeon during this operation.
- 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 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  Date

Doctor's name   
*(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)*