



CONSENT FORM FOR DISTAL PARTIAL GASTRECTOMY

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

AFFIX LABEL HERE

PROPOSED TREATMENT

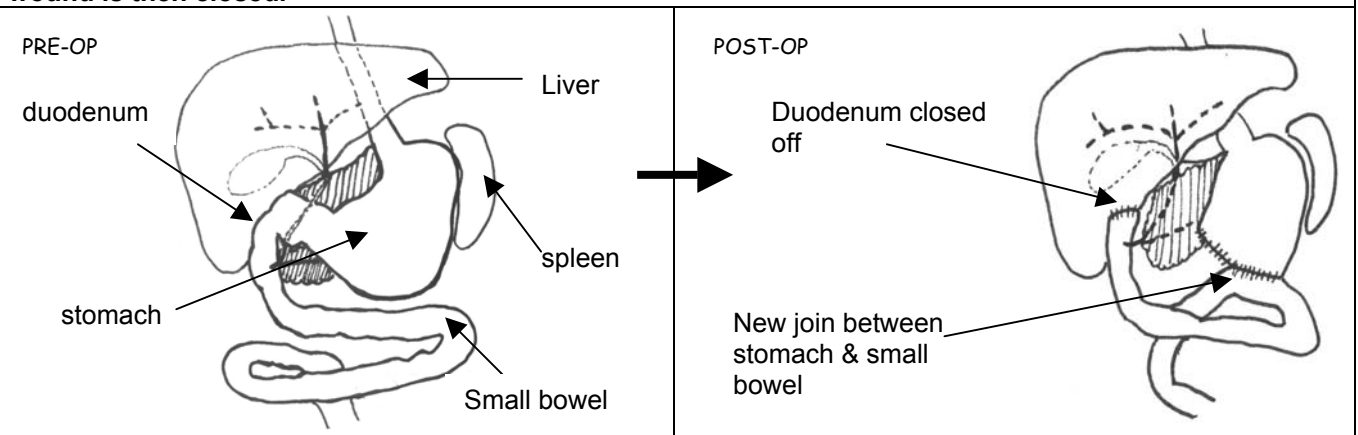
The doctor has explained that I, (*name of patient*), have the following condition:.....
and that a **distal partial gastrectomy** is proposed:

This means an operation to remove the lower part of the stomach and associated lymph nodes.

Under a general anaesthetic, a cut is usually made in the upper midline of the abdomen. The surgeon examines the abdominal organs to assess the extent of the disease, and if necessary may take small pieces of tissue (biopsies) for more detailed microscopic examination.

The surgeon decides how much of the stomach and first part of the small bowel (duodenum) need to be removed and ties off the blood vessels supplying blood to that area. Clamps are placed across the freed area of stomach and small bowel and the diseased tissue is removed and sent for pathological examination. The free end of the small bowel is closed with stitches or staples. A loop of small bowel is placed next to the cut end of the stomach and a new opening is created between the stomach and the small bowel.

One or more drains may be left close to the operation site to remove secretions, and a tube passed through the nose and into the stomach to rest the bowel until normal activity returns. The abdominal wound is then closed.



RISKS

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

- I may develop a clot in my legs (deep vein thrombosis), causing pain and swelling. Part of this may come loose and travel to my lungs (pulmonary embolus). This may make me short of breath and occasionally may even be fatal.
- I may develop areas of minor collapse in the lungs, increasing my risk of getting a chest infection. I may require treatment with physiotherapy.
- I may have a heart attack from strain on my heart or a stroke.
- I may have some bleeding after the operation. This may rarely require a second operation or possibly a blood transfusion.

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

- During the operation, organs close to the site such as the spleen, gall bladder and pancreas, may be inadvertently damaged, and require repair or removal.

RISKS CONTINUED OVERLEAF →

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FOR
DISTAL PARTIAL
GASTRECTOMY**

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RISKS CONTINUED

- The join between the stomach and small bowel may break down, allowing stomach contents to leak into the abdominal cavity causing peritonitis. This usually requires a second urgent operation.
- Food may not pass easily from the stomach into the small bowel through the new opening. This may require further intervention.
- Food may pass too rapidly from the stomach into the small bowel causing the symptoms of dumping (nausea, vomiting, diarrhoea, cramps and dizziness).

I understand 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 general 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 general 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 general 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 general surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If any staff member is exposed to my blood (needlestick injury) then I consent to a sample of my blood being collected for testing for infectious diseases, such as Hepatitis B, C and HIV. I understand that the blood sample will not be tested until I have been informed and I have given my consent.

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*)