



# CONSENT FORM FOR HAEMORRHOIDECTOMY

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

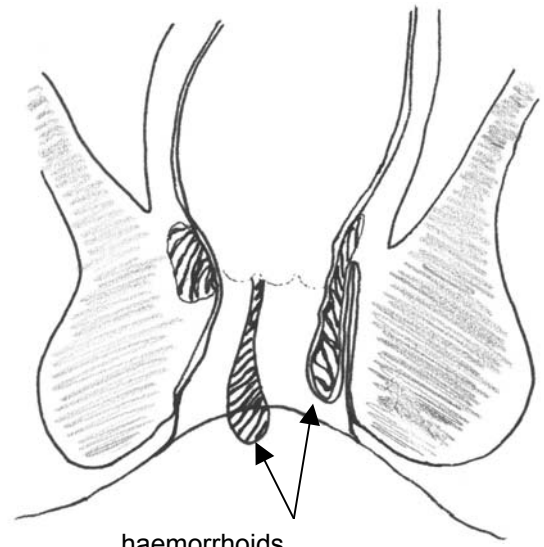
## PROPOSED TREATMENT

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

**This means an operation to surgically remove prolapsing haemorrhoids (piles). Surgical techniques vary; one option is described below for information.**

**Under a general anaesthetic, the surgeon grasps each pile in turn using a clamp and dissects the pile and its stalk away from the anal canal. A stitch is then used to tie off the blood supply to the pile and it is cut off.**

**Most patients have three piles and when each has been dealt with, any remaining bleeding is stopped and in some cases, the raw edges are closed using an absorbable stitch. Some paraffin gauze may be left in the wounds temporarily.**



haemorrhoids

## 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 a **haemorrhoidectomy** 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.

I understand a **haemorrhoidectomy** has the following **specific risks and limitations**:

- Having my bowels open after the operation may be painful for a few days and I may become constipated.
- Occasionally the wounds are severely painful.
- I may have difficulty passing urine after the operation.
- I may have some bleeding if the deep stitches slip or when they separate as part of normal healing in ten days' time or so. This can be severe and I may have to be readmitted to hospital. Rarely I may even need a blood transfusion or re-operation.
- The wounds may become infected.
- I may have difficulty controlling my bowel motions.
- One of the wounds may fail to heal and require a second short procedure to stretch the anal muscles and promote healing (anal fissure).
- The operation does not deal with the underlying problem, which may include excessive straining to pass a motion. In some cases, this means the piles may recur.
- Very rarely, the wounds may heal with tight scar tissue and cause longer term difficulty in having my bowels open (anal stricture).

RISKS CONTINUED OVERLEAF →

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FOR  
HAEMORRHOIDECTOMY**

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**RISKS CONTINUED**

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**  
(*print name*)

**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*)