



CONSENT FORM FOR INSERTION OF VENTRICULO- PERITONEAL (VP) SHUNT

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*), have **hydrocephalus** due toand that **insertion of a VP shunt** is proposed:

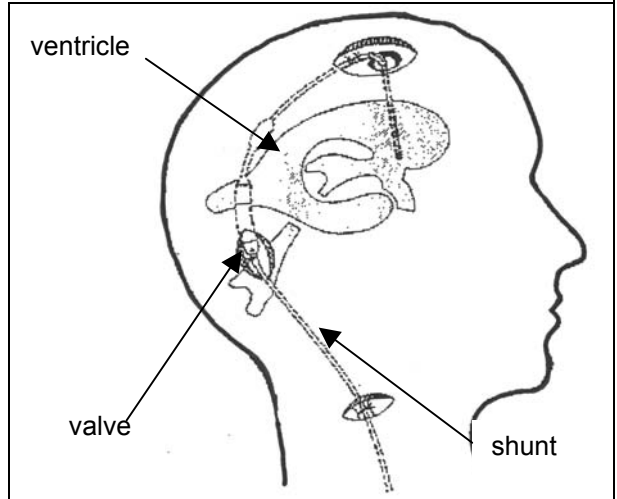
This means placing a silicone drain from one of the brain's fluid collection areas (ventricles) to the abdominal cavity to relieve cerebrospinal fluid (CSF) collecting within the brain (hydrocephalus). CSF enters the shunt in the ventricle, passes through the regulating valve and into the abdomen where the fluid is absorbed back into the bloodstream.

Under a general anaesthetic, a urinary catheter may be inserted to keep the bladder empty. Fluids and drugs may be given through an intravenous cannula.

A cut is made in the scalp and a small hole made in the skull. The abdominal cavity is opened through a separate cut.

The ventricular catheter is inserted through the brain tissue into the enlarged lateral ventricle. A valve is attached which will lie between the skull and scalp.

The abdominal catheter is then inserted under the skin of the neck and tunnelled under the skin of the chest and abdomen. Its top end is attached to the valve and the lower end is inserted into the abdominal cavity.



RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your neurosurgeon 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 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. If part breaks off, it may travel to my lungs (pulmonary embolus), making me breathless. Occasionally it may even cause death.
- I may develop areas of minor collapse in the lungs, increasing my risk of a chest infection. I may require treatment with physiotherapy.
- I may have a heart attack from strain on my heart.
- I may develop an infection associated with the urinary catheter or the intravenous lines, that may require antibiotic treatment

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

- My wound or the operation site may bleed. This may settle spontaneously but if not, I may require further surgery for control.
- My shunt, brain, abdomen or skin wounds may become infected. Antibiotics will be given to me before the operation to reduce this risk, but I may also require them afterwards in certain circumstances.
- Rarely, the shunt may cause injury to my brain causing paralysis, loss of sensation, speech loss or abnormality, visual loss or disturbance, seizures, memory loss or other loss of brain function.
- The shunt may also cause injury to abdominal organs including the bowel, liver or spleen. In this case, I may need surgery to treat the injury.
- If the shunt fails it may become obstructed, the catheters may separate, the valve may fail or any of the other shunt components may fail. I would need more investigations and usually further surgery.
- The peritoneal catheter may break, blocking the shunt or the lower end of the catheter may fall loose into my peritoneal cavity. Although this may not cause any problems, a loose catheter is normally removed when the shunt is revised.

RISKS CONTINUED OVERLEAF →

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FOR
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RISKS CONTINUED

- If there is over-drainage of cerebrospinal fluid, I may develop headaches.
- Blood or fluid may collect over my brain surface and may require treatment.
- The ventriculo-peritoneal shunt may cause me abdominal complications including hernia, fluid collection in my abdomen, twisting of my bowel or perforation of my bowel or bladder

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 neurosurgeon 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 neurosurgeon 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 neurosurgeon 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 neurosurgeon may perform the procedure.
- I understand that no guarantee has been given to me that this operation will be successful.
- 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)			