



CONSENT FORM
FOR
ABLATION OF
GENITAL WARTS

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
have **genital warts** and that **ablation of the genital warts** is proposed:

This means treating the skin growths caused by the genital warts virus surgically. Under a general anaesthetic, the warts are picked up in fine forceps one at a time and burned off with an electrical current. Only small areas are treated at each operation as the burns may be painful for some days while they heal. A sample may be sent for microscopic examination.

RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your gynaecologist 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 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 specialist gynaecologist 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 specialist gynaecologist 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 specialist gynaecologist 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 have received a copy of this form to take home with me.
- I understand that a doctor other than the specialist gynaecologist may perform the procedure.
- If any staff member is injured or exposed to my blood or other body fluid then I give my consent to a sample of my blood being collected for the purpose of testing for infectious diseases, such as Hepatitis B, C and HIV. I understand that no testing of the blood sample will be carried out without prior discussion and my explicit consent.
- **I agree* / do not agree*** to a **vaginal examination** by the Medical Student assigned to me, supervised by a doctor, while I am anaesthetised, if it is considered that a vaginal examination is a necessary part of the operation. (** delete one of these statements*)

Signature of patient

.....

Date

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MR CONSENT FORM FOR ABLATION OF GENITAL WARTS

**CONSENT FORM
FOR
ABLATION OF GENITAL WARTS**

Med Rec. No.....
Surname:.....
Forename:.....
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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 <i>(please print)</i>	Date
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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
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Interpreter's name <i>(please print)</i>	
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If the patient is unable to give consent a proxy form must be completed and attached.