OPEN PROSTATECTOMY SURGERY CONSENT FORM

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PATIENT'S

Patient File

No:…….

Name, Surname :……

Birthdate :…….

Sex :…….

Division :……..

Consent Date :……..

Dear patient / deputy legal representative;
You have the right to be informed on the medical, surgical and diagnosis related procedures about your/your patient's health status and recommended for you/your patient, and their alternatives, benefits, risks and even possible damages that could take place, and to refuse or to accept all or part of these, or to stop the procedures to be conducted in any phase.
This form, which we ask you to read and understand, has been prepared to inform you on determining whether you will give consent for the applications or not, and to obtain your permission, and not to frighten you or scare you away from these medical applications.

INFORMATION

PRE-DIAGNOSIS :……..

PLANNED TREATMENT / ESTIMATED DURATION……..

INFORMATION ABOUT THE PROCEDURE

Open prostatectomy is performed under general or spinal anesthesia. The incision is made horizontally from 5-6 cm inferior to the navel . The bladder is opened and enlarged prostate tissues are removed through bladder. Then, the bladder is closed with absorbable sutures. Then, a catheter is placed in the bladder through both the abdomen and the urinary canal. In addition to these, a drain is placed in the operative field.

ALTERNATIVE TREATMENTS

LEAVE BLANK

POSSIBLE COMPLICATIONS REGARDING PROCEDURE

1.Urine leakage may occur from the area where the bladder is sutured. Leakage may occur onto the skin surface and continue for a while.
(%5-9).

2.Catheters in the bladder may be blocked due to bleeding and cause urinary urgency.
3.Bleeding may occur in the abdominal cavity. May require fluid replacement or surgical treatment.
4.There may be severe bleeding in the area where the prostate is removed. For this reason, blood or blood products may need to be given.
Another attempt may be required with a closed or open method (1%-
5.Inflammation accumulation in the abdominal cavity and infection may occur. Surgical drainage or antibiotic treatment may be required (0.5-3%).
6.After surgery, intestinal movements may slow down or stop completely. As a result of fluid accumulation in the intestines this case can cause bloating and vomiting. This situation may require treatment (0.1-2%).
7.Over time, weakness may occur in the wound area. The wound may be completely or partially opened in a short period of time. Hernia may occur in the long term (0.5-3%).
8.If the area where the prostate is removed does not heal properly, urinary canal stricture may occur in the long term.
9.In some patients, wound healing may be abnormal, in this case the wound may thicken. The wound may be red and painful (1-4%).
10. In some patients, pre-existing urination complaints may partially decrease, continue, may increase, and drug therapy may be needed.
11. The growth in complaints of urinary incontinence or urinary incontinence may develop in 1-5% of the postoperative patients.
12. After the surgery, 1-2% of patients may develop erectile dysfunction.
13. In postoperative patients, followig may occur: ejaculation dysfunction, semen leakage to bladder and, when urinating, semen comes out with urine (1-4%).
People who are overweight have increased risk of wound and breast infections, heart lung complications, and thrombosis.

INFORMATION ABOUT THE SUCCESS RATE

INFORMATION ABOUT THE POSSIBLE CONSEQUENCES IN CASE OF REFUSAL OF PROCEDURE

(IF MEDICINE USE IS PLANNED) INFORMATION ABOUT OF SPECIFIC MEDICINE AND ITS FEATURES

IMPORTANT LIFESTYLE SUGGESTIONS FOR PATIENT'S HEALTH

ACCESS TO MEDICAL ASSISTANCE ON THE SAME SUBJECT WHEN NECESSARY

According to health legislation, every individual has the freedom to choose hospital and physician. You can reach medical assistance in public or private health organizations about your disease within the scope of your Social Security. When necessary, you can contact our hospital 24 hours a day, or you can get medical assistance by contacting the doctor or another specialist who performed the surgery with the phone number **0090 (222) 335 0 335**. In case of emergency, you are be able to get medical assistance at a health care facility near you or via an emergency call center (112).

PATIENT'S QUESTIONS (IF ANY)

CONSENT

I have been told all the results I might have had if I am not treated or if I refused the treatment, and, in respect of all the procedures to be performed while diagnosis and treatment, I have been explained plainly and explicitly that I may encounter with infection, blood coagulation in veins and lungs, bleeding, allergic reaction or oedema at or far from surgical area, epileptic seizure, temporary or permanent organ/system functioning failure, death, including anameia and meningitis.

We know the other risks may be side effects, such as hypokinesis in section area, permanent scar, body deformation as a result of bone subtraction/addition, cerebral fluid leakage from surgical area or needle site, headache or longterm/chronic ache, temporary or permanent voice loss causing from vocal cord palsy, temporary or permanent function loss in organs such as face, brow, tooth, eye or hearing impairment, swallowing impairment and vision loss and loss of bladder and stool control, changes in personality, become disabled due to tissue or organ damage and occurrence of need to use medicine/hormones for a lifetime, short or longterm ache due to position during the operation, and narcotism; and hereby approve these mentioned risks.

I have read the above given information and have been informed by the undersigned doctor. I have been informed about the purpose, risks and complications of the medical or surgical intervention to be performed. I approve this process consciously, without further explanation and under no pressure I hereby authorize the person named …… with giving approval and being informed about my treatment if I lose my consciousness by some means or another and am not able to give approval during the operations related to my treatment.

…….(Please write "I acknowledge that I have read and understood above" in your handwriting)

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PATIENT

Time: Signature: Date:……

Name Surname (handwriting):……..

Patient's father/mother/legal representative* Signature:

Date / Time:

Name Surname (handwriting):……..

*The person whose name is mentioned in the last paragraph should sign.

I have made adequate and satisfactory explanation to aforementioned patient / patient relative about the disease, operation to be performed, the reason and benefits of the operation, necessary postoperative care and probable risks, type of anaesthesia to be applied, if necessary, and risks and complications regarding anaesthesia. The patient / patient relative has signed and approved this form with their own consent that they have been adequately informed on the operation.

DOCTOR

Date / Time: Signature:

Name Surname:…….

IF THE PATIENT HAS SPEECH / LANGUAGE DIFFICULTIES:

I have interpreted the statements made by the doctor to the patient. In my opinion, the information I have interpreted is understood by the patient.

INTERPRETER'S:

Date / Time: Signature:

Name Surname (handwriting):…….

You can consult with Patient Services Directorate during the day and the Night Chief during the nights for all your complaints or any other issues you wish to address about medical applications.

*Legal Representative: The guardian for those under guardianship, the parents for minors, in cases where they do not have one of these, first degree lawful heirs. Signing this consent form does not abolish the patient's legal rights.