BREAST LUMP REMOVAL CONSENT FORM

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Revision Cause:

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

Axillary ganglions (armpit lymph nodes) are the lymph nodes at which breast lymph circulation stops by first after breasts. It has been explained that, during the surgery, due to the cancer, it might be necessary to remove the cancerous tissue, or if necessary, the whole breast, along with armpit lymph nodes. If the surgical intervention is not performed, breast cancer may progress, and other therapy methods (such as chemotherapy, radiotherapy, hormonotherapy) will be less effective when applied merely.

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ALTERNATIVE TREATMENTS

POSSIBLE COMPLICATIONS REGARDING PROCEDURE

1. Surgery Scar Surgical incision onto breast and armpit is generally done by following skin tags. The scar is generally followed by a stria or heals nearly completely, but some patients may end up with thicker and more swollen scar. This is rare, but if there is any other scar formerly formed on your body, please inform the surgical team.

2. Fat Necrosis: Sometimes, because the blood vessels of fat tissue and breast tissue are cut off, pain and mass may occur in the breast. A decline will be achieved in the period of approximately 12 months.

3. Axillary Dissection: When all the armpit lymph nodes are removed, numbness, discomfort, and stiffness in armpits and upper arm may occur. Numbness will gradually decrease over time. Arm exercises after the operation will accelerate the healing process.

4. Seroma: Seroma is accumulation of fluid in the arm and under the skin flap after surgery. When such a situation occurs, it requires the discharge of the liquid using injector.

5. Lymphedema: This means the subcutaneous tissue swelling occuring if the lymph fluid can not be drained. This condition occurs as a result of removal of lymph nodes(surgery)or secondary blocking of scar tissue (radiotherapy). The condition may develop at any time after surgery.

6. Other Possible Problems: After each operation, problems such as infection, bleeding, etc. may occur.

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)

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.