	(Affix patient identification label here)					
	URN: Family Name: Given Names: Address:					
Microvascular Decompression						
for Trigeminal Neuralgia						
Facility						
Facility:	Date of Birth: Sex: \( \bullet M  \text{F} \)					
A. INTERPRETER / CULTURAL NEEDS	<ul> <li>Uncommon risks include;</li> <li>Cranial nerve damage. This may result in loss of</li> </ul>					
An Interpreter Service is required?	hearing, facial weakness & numbness, double					
If Yes, is a qualified Interpreter present?						
A Cultural Support Person is required?	l li colora a colorali con Thia con a colora de conseguencia co					
If Yes, is a Cultural Support Person present? Yes No	permanent and may require a second operation.					
<b>B. CONDITION AND TREATMENT</b>	<ul> <li>Brain fluid leakage can occur after the operation.</li> <li>This may require further surgery.</li> </ul>					
The doctor has explained that you have the following condition: (Doctor to document in patient's own words)	<ul> <li>Infection inside the brain. This will require further treatment.</li> </ul>					
words)	<ul> <li>Weakness of chewing muscles on the effected side of your face. This is usually temporary.</li> </ul>					
This condition requires the following procedure.	<ul> <li>Heart attack. A heart attack because of the strain on the heart or a stroke.</li> </ul>					
(Doctor to document - include site and/or side where relevant to the procedure)	<ul> <li>Clots in the leg (deep vein thrombosis or DVT) with pain and swelling. Rarely part of this clot may break off and go into the lungs.</li> </ul>					
	Rare risks include;					
The following will be performed:	<ul> <li>Bleeding inside the head or brain. This would require further surgery.</li> </ul>					
Trigeminal Neuralgia is a disorder of the trigeminal	<ul> <li>Meningitis. This would require further treatment.</li> </ul>					
nerve which at times causes intense pain in the face.	Seizures. This would require further treatment.					
This procedure involves having a small cut made behind the ear on the same side as the pain. A small	<ul> <li>Death is rare due to this procedure.</li> </ul>					
amount of bone will be removed from the skull. A microscope is then used to identify the trigeminal nerve and the blood vessels compressing the nerve.	D. SIGNIFICANT RISKS AND PROCEDURE OPTIONS					
Once this is done the surgeon will place some protective cushioning (usually Teflon) between the vessel and the nerve to ensure separation. The	(Doctor to document in space provided. Continue in Medical Record if necessary.)					

# C. RISKS OF A MICROVASCULAR **DECOMPRESSION FOR TRIGEMINAL NEURALGIA**

removed bone will be replaced with metallic plates and screws. The skin will be closed with sutures.

There are some risks/complications with this procedure/treatment/investigation.

### Common risks include;

- · Failure to adequately relieve the pain.
- Bleeding. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Asprin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung may collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increase risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.

# E. RISKS OF NOT HAVING THIS **PRCOEDURE**

(Doctor to document in space provided. Continue in Medical Record if necessary.)

### F. ANAESTHETIC

This treatment/procedure/investigation may require an anaesthetic. (Doctor to document type of anaesthetic required)

# Microvascular Decompression for Trigeminal Neuralgia Facility: Date of Birth: (Affix patient identification label here) URN: Family Name: Given Names: Address: Date of Birth: Sex: M F

# **G. PATIENT CONSENT**

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure/treatment/investigations, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure/treatment. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure/treatment.
- that no guarantee has been made that the procedure/treatment will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated accordingly.
- a doctor other than the Specialist Neurosurgeon may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheets:

- □ About your Anaesthetic
- ☐ Microvascular Decompression for Trigeminal Neuralgia
- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure/treatment/ investigations and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time before the procedure/ treatment/investigation, including after I have signed this form but, preferably following a discussion with my doctor.

On the basis of the above statements.

I REQUEST TO HAVE THE PROCEDURE Name of Patient/ Substitute decision maker and relationship:
Signature:
Date:
Substitute Decision-Maker: Under the Powers of Attorney Act 1998 and/or the Guardianship and Administration Act 2000. If the patient is an adult and unable to give consent, an authorised decision-maker must give consent on the patient's behalf.

## H. DOCTOR'S STATEMENT

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

maker has understood the information.
Name of
Doctor:
Designation:
Signature:
Date:
Name of
Anaesthetist:
Designation:
Designation: Signature:

	ΓER					

I have given a sight translation in

(state the patient's language here) of the consent form and assisted in the provision of any verbal and

written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter:

Date: