

<h2 style="margin: 0;">Posterior Fossa Decompression</h2>	<p>(Affix patient identification label here)</p> <p>URN:</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p>
<p>Facility:</p>	

A. INTERPRETER / CULTURAL NEEDS

- An Interpreter Service is required? Yes No
- If Yes, is a qualified Interpreter present? Yes No
- A Cultural Support Person is required? Yes No
- If Yes, is a Cultural Support Person present? Yes No

B. CONDITION AND TREATMENT

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....

.....

This condition requires the following procedure/treatment/investigation. *(Doctor to document - include site and/or side where relevant to the procedure)*

.....

.....

The following will be performed:

A Posterior Fossa Decompression is done to relieve the constriction and create more space at the base of the brain.

The procedure involves a cut being made into the tissues at the back of the head and the neck bones covering the base of the brain.

A small section of bone is removed from the base of the skull and at times from the upper back. In many cases the above procedure is enough to relieve the constriction and nothing further is required.

However, in some cases there is a tight band of tissue or scar tissue around the base of the brain which constricts the lining of the brain.

For this reason the lining of the brain is opened to allow further relief. Through a separate cut, a tissue graft is taken from the patient's thigh and placed in the opening of the brain. It is stitched into position to widen the opening and create more space for the base of the brain.

The bone will be left out and the cut is closed with sutures or clips.

C. RISKS OF A POSTERIOR FOSSA DECOMPRESSION

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

Common risks include;

- Infection. This may need antibiotics and further treatment.

- Minor pain, bruising and/or infection from IV cannula site. This may require treatment with antibiotics.
- Bleeding. A return to the operating room for further surgery may be required if bleeding occurs. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).

Uncommon risks include;

- A heart attack because of the strain on the heart.
- Stroke or stroke like complications can occur which can cause weakness in the face, arms and legs. This could be temporary or permanent.
- Fluid leakage from around the brain can occur after the operation. This may require further surgery.
- The problem may not be cured by surgery. This may require further treatment.
- 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.
- 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.

Rare risks include;

- Death is rare due to this procedure.

D. SIGNIFICANT RISKS AND PROCEDURE OPTIONS

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

.....

.....

E. RISKS OF NOT HAVING THIS PROCEDURE

(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)*

Posterior Fossa Decompression

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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**
- Posterior Fossa Decompression**
 - 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.

**Name of
Doctor:**.....

Designation:

Signature:.....

Date:.....

**Name of
Anaesthetist:**.....

Designation:

Signature:.....

Date:.....

I. INTERPRETER'S STATEMENT

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:**

Signature:.....

Date:.....