

Email: foi.tsdfd@nhs.net
Our Ref: TSD8960

15 October 2026

Dear Sir/Madam

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below as of June 2025:

We would ask for your NHS Trust to provide information on two aspects:

- 1. Whether safety screening forms or checklists which are completed by patients prior to a diagnostic imaging examination are in paper form or in digital format (e.g. web-based or tablet)?**

This includes but may not be limited to:

- **Inclusive Pregnancy status (IPS) or last menstrual period (LMP) forms**
- **Magnetic resonance imaging (MRI) safety forms**
- **Contrast media administration (all modalities)**
- **Bone densitometry (DXA) patient questionnaire**
- **Any other examination-specific forms e.g. CT colonography or cardiac questionnaires.**

[All forms are currently in paper format.](#)

- 2. If any of these are completed in paper form, we would ask for a copy of the current version to be sent via email.**

[Please see documents attached.](#)

- [Bone Scan](#)
- [Consent Form \(Joint – Bursa - Muscle – Tendon\)](#)
- [Consent Form \(MR Arthogram\)](#)
- [Consent Form \(Nerve Root Blocks\)](#)
- [Consent Form \(Pregnancy\)](#)
- [Consent Form \(X Ray Pregnancy\)](#)
- [COVID-19 Steroid Injection Letter to Patients](#)
- [CT Scanning All Exam Patient Checklist](#)

- DaTSCAN
- MRI Safety Questionnaire
- Patient Agreement to Investigation or Treatment
- Patient Agreement to Investigation or Treatment Cardiac Catheterisation
- Patient Agreement to Investigation or Treatment Coronary Angiogram
- Patient Agreement to Investigation or Treatment Pacemaker Implantation
- Pregnancy Override Form
- Renogram

We do not require information regarding staff completed forms e.g. WHO safety forms however, we would request that forms initially completed by a patient and co-signed by a staff member at the time of the examination are included.

The information supplied to you continues to be protected by the Copyright, Designs and Patents Act 1988. You are free to use it for your own purposes, including any non-commercial research you are doing and for the purposes of news reporting.

If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Complaints Manager at Torbay and South Devon NHS Foundation Trust, First Floor Bowyer Building, Torbay Hospital, Torquay TQ2 7AA or by email to tsdft.feedback@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the complaints and/or internal review process provided by us. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link <https://ico.org.uk/global/contact-us/>

Yours sincerely,

Freedom of Information Team

Patient Information about

Bone Scan

Bone scans are used to detect arthritis, fractures, bone infections, tumours and evaluating unexplained bone pain.

A special liquid called a radioactive tracer will be injected into a vein in your arm. This enables us to obtain images of your bones when we scan you. The radiation dose you will receive is the equivalent of 219 days of background radiation when living in Devon. This is classed as a low risk procedure, but has been deemed beneficial to your diagnosis by your referring doctor. The injection takes at least 2 and a half hours to be taken up into your bones. When you have your injection, you will be given a time to come back for your scan. During your scan we will ask you to lie on an imaging table for approximately 30 minutes.

Important Instructions

- You can eat and continue to take any prescribed medication as normal
- We will ask you to drink 6 to 7 cups of fluid between your injection and scan
- As you will be given a radioactive injection, please avoid **close prolonged contact** with pregnant women or children for 48 hours after your injection
- When in the department please only use the Nuclear Medicine toilet. Once further on from the chapel, any toilets within the rest of the hospital may be used
- You can leave the department between your injection and scan if you wish
- You will be asked to wear a yellow wristband for the next 48 hours to identify to other healthcare staff that you are radioactive

Consent:

- ☐ I have read the above information
- ☐ I consent to having the radioactive injection
- ☐ I am not pregnant or breastfeeding

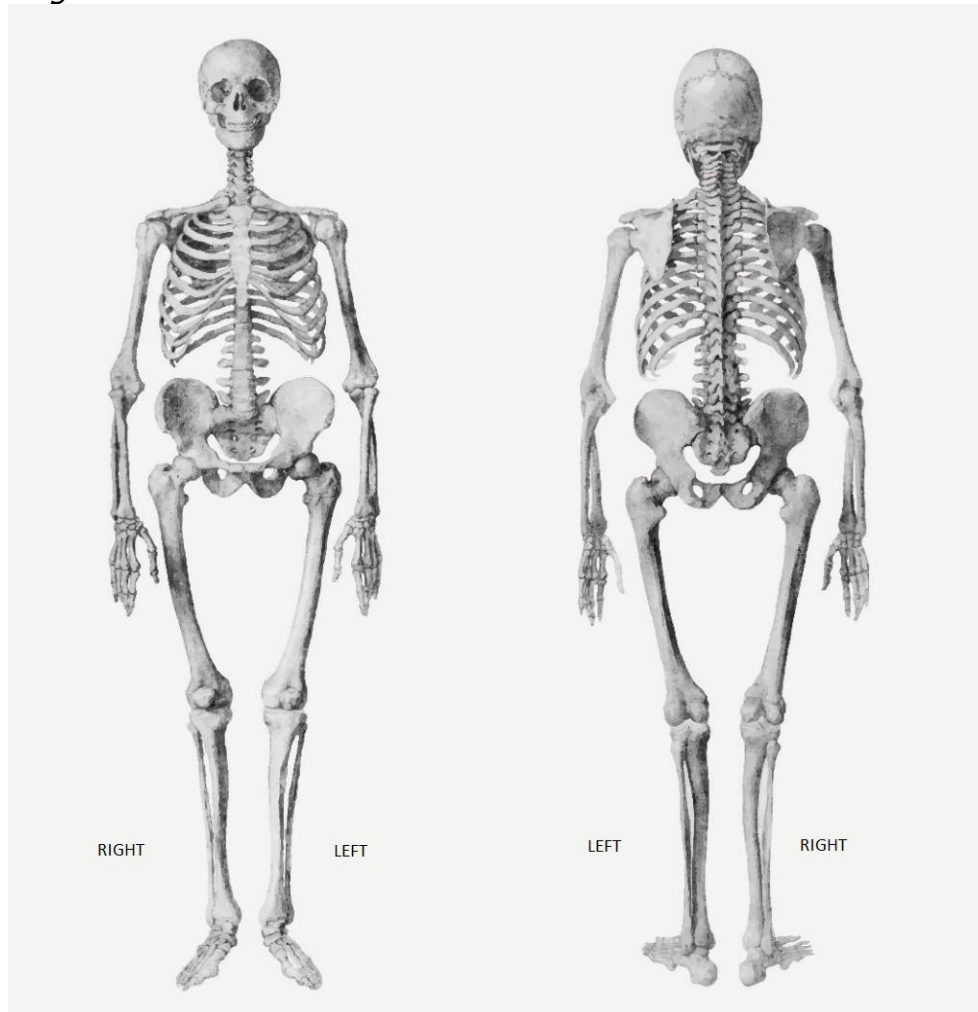
Weight:.....Height:.....

Name:.....

Signed:.....Date:.....

Patient Bone Scan Questionnaire

1: Do you have any specific areas of aches or pains? *Please circle area on diagram below*



2: **Have you broken any bones in the last 3 years?** YES NO

If yes, then please state which ones _____

3: **Do you have any joint replacements?** YES NO

If yes, then please state which joints _____

4: **Have you recently undergone radiotherapy?** YES NO

If yes, then please state which body part _____

5: **Have you had any trips, falls or bruises in the last 3 months?**

YES NO

If yes, where did you hurt yourself? _____

6: **Have you had any dental work in the last 3 months?** YES NO

If yes, then please state what _____

RADIOLOGICALLY GUIDED INJECTION CONSENT FORM

JOINT / BURSA / MUSCLE / TENDON SHEATH INJECTIONS

The purpose of this document is to provide written information regarding the risks, benefits and alternatives to the injection you have been referred for today. This is supplementary to the discussion you have already had with your clinical referrer. You **must** have tried all alternative therapies, treatments, exercises, and activity modifications before being referred for this appointment and they **must** have proven unsuccessful. It is important that you fully understand this information, so please read this document carefully.

BENEFITS

You **may** receive the benefit of pain relief and improved mobility following this procedure, but this cannot always be guaranteed. Please consider carefully if these potential benefits outweigh the risks. The World Health Organisation and many other medical societies have declared that steroid injections are **not** recommended during the global Covid-19 pandemic. Please bear this in mind when considering your decision to proceed with this treatment.

RISKS

Before undergoing the procedure, understanding the associated risks is essential. No procedure is risk-free. The following risks are well recognised, but there may also be risks that have not been included in this list that are unforeseen by the performing physician.

- There may be allergic reactions to the medicines injected, to the tape or equipment used (such as latex), chemicals used to clean the skin, or an adverse interaction with your prescribed medication, for instance. This may be localised to the injection site or be a whole body response. You will be asked a series of safety questions prior to the procedure to minimise this risk.
- There may be infection, although this is rare. You may develop 'post-injection flare' which is swelling and pain several hours after the corticosteroid injection.
- Joint, tendon, or cartilage damage may result from a single but more likely, frequent corticosteroid injections. Generally, repeated and numerous injections into the same site is discouraged.
- The blood supply to the bones surrounding the joint may become compromised by a condition called avascular necrosis. Whilst this is rare should this condition occur surgery is a possible consequence.
- There may be de-pigmentation (a whitening) of the skin.
- There may be local fat atrophy (thinning of the skin) at the injection site
- There may be pain associated with this procedure and the healing process.
- **Injected steroids can reduce the function of the immune system for several weeks which means that there is a potentially increased risk of becoming infected with coronavirus (COVID-19) or other viruses. In a small proportion of patients that can lead to serious complications, including serious lung damage, which in the worst cases could require admission to an Intensive Care Unit (ICU/ITU) and ventilation and possibly death.**

WARNINGS

- Female patients may experience heavier menstrual periods than normal related to a hormonal response to the steroid.
- There may be a sensation of flushing of the face, neck and upper chest (this may occur up to a few days after the procedure)
- You should refrain from driving until the following day.
- You may experience a flare up of symptoms prior to the medication taking effect. The duration and onset of pain relief is variable.
- You must seek advice from your GP or medical prescriber prior to adjusting your prescribed medication, following the procedure.
- If you feel flu-like or feverish symptoms; or a redness or pain around the injection site within the first week after the injection, you should seek advice from your GP or walk in centre (during opening hours); or emergency department (out of hours)

ALTERNATIVES

- You may wish to make an appointment with the doctor or healthcare professional who referred you for this treatment to discuss your treatment options and to consider repeating alternative therapies.
- Do nothing. The procedure is performed at your discretion. If your symptoms have improved since the referral was made, please inform the performing physician.

PROCEDURAL CHECKLIST	YES	NO
Allergies If yes , please state:		
Anti-coagulants (blood thinning medication) If yes , state the name of the medication:		
Anti-smoking medication (Zyban)		
Anti-retroviral medication (a treatment for HIV)		
Diabetes		
Someone to drive home		
Pregnant		
Breast feeding		
I can confirm that I have tried all alternative therapies, treatments, exercises, and activity modifications before being referred for this appointment and they have not been successful in treating my pain.		
I can confirm that I do not have symptoms of a viral illness, such as Covid-19. I do not have a high temperature, a new (continuous) cough, or a loss or change to my sense of smell or taste.		
I can confirm that I will socially distance and wear a face mask in enclosed public spaces for a further 14 days after this injection as I will be temporarily immunosuppressed and at greater risk of contracting and fighting coronavirus, which may have fatal consequences (as described <u>overleaf</u>)		
I can confirm that I have not received a Covid-19 or Flu vaccination within the last two weeks or have one booked within the next two weeks.		

CONSENT TO THE PROCEDURE:

Please sign the form below once you have read and understood the information provided overleaf. By signing this form, you have agreed to proceed with treatment considering the information and possibility of complications, as detailed.

Patient name.....

Site and laterality to be injected..... (e.g. right hip joint)

Site confirmed with patient ☐ (Place a tick ✓ in the box)

I consent to the injection procedure, have read and understood the information overleaf and have provided accurate details for the procedural checklist. I am in agreement with the site to be injected today. I understand the alternatives to this treatment and have been provided the opportunity to refuse the procedure. I have made this decision by myself and have not been influenced by anyone in the process of reaching this conclusion to proceed. I have understood the possibility of the risks and complications as detailed, which could have fatal consequences, and am happy to accept this and consent to the procedure. I will adhere to the post injection requirements for 14 days as outlined above.

Signature of patient..... Date.....

I have checked the information on this form with the patient and have also provided additional verbal information and explanation, personalised to the patient, until they have confirmed to me that they are happy for me to proceed with the injection into the above named site.

Signature of performing physician.....Date.....

RADIOLOGICALLY GUIDED INJECTION CONSENT FORM

MRI ARTHROGRAM

You have been advised by your doctor, or other referrer, to have an MRI arthrogram. This is a special procedure that uses both x-rays and a powerful magnet to produce very detailed images of the joint being examined. Special MRI and X-ray contrast media (or “dye”) will be injected into your joint under x-ray guidance before your MRI scan.

What are the benefits of the procedure?

Gadolinium contrast media (sometimes called MRI contrast or “dye”) is used to better assess an injury or symptom that you may be experiencing. It allows the internal structure of the joint and soft tissues (such as cartilage and ligaments) to be seen in more detail on the MRI scan, which may improve the information we obtain about what is wrong within the joint. An MRI arthrogram is usually performed if patients have persistent pain within a joint and damage to the internal structures is suspected. It may help your doctor, or other referrer, to obtain a diagnosis to plan for any further treatment you may require.

What are the risks of the injection?

- It is possible that you may have an allergic reaction from the contrast agents (MRI or X-ray “dye”) used;
- There is a very small risk of an infection being introduced into the joint;
- You may get pain, tingling, numbness, or a heavy feeling in your limb that could last a couple of hours;
- Very rarely patients feel light headed during the procedure; their blood pressure may drop and they may feel faint; and
- Exposure to X-rays carries a small risk, but your referring clinician feels that this risk is outweighed by the benefits of having the test. We will take precautions to minimise the amount of X-rays you receive.

To reduce the risks of the injection, **please complete the following checklist:**

PROCEDURAL CHECKLIST PRIOR TO THE INJECTION	YES	NO
Do you have any allergies? If yes , please state:		
Do you take any medication to thin your blood (such as Warfarin, Aspirin, Clopidogrel, Rivaroxaban)? If yes , state the name of the medication:		
Do you have someone to drive you home?		
Do you have claustrophobia (a fear of small or confined spaces)?		

What are the risks of the MRI scan?

Assuming it has been considered safe for you to receive an MRI scan, there should no short term harmful effects. **Please complete the risk assessment (“MRI Safety Questionnaire”) overleaf.**

CONSENT TO THE PROCEDURE:

I consent to the injection procedure, have read and understood the information provided and have provided accurate details for the Injection and MRI checklists. I am in agreement with the site to be injected today. I have understood the possibility of the risks and complications as detailed, and am happy to accept this and consent to the procedure.

Patient name.....

Site and laterality to be injected..... (e.g. right hip joint)

Signature of patient..... Date.....

I have checked the information on this form with the patient and have also provided additional verbal information and explanation, personalised to the patient, until they have confirmed to me that they are happy for me to proceed with the injection into the above named site. I have confirmed both the site and laterality with the patient.

Signature of performing physician.....Date.....

PLEASE COMPLETE THE MRI SAFETY QUESTIONNAIRE ON THE NEXT PAGE

MRI SAFETY QUESTIONNAIRE

Patient Name _____ Daytime Tel. No. _____

Date of Birth _____ Height _____ Weight _____ Occupation _____

Please indicate if you have, or have ever had, any of the following:	Yes	No
Brain surgery e.g. cerebral aneurysm clips or coils	☐	☐
Heart or chest surgery e.g. cardiac pacemaker, LINQ device	☐	☐
Mechanical, magnetically activated or electronic implants/devices e.g. brain/spinal neuro-stimulators	☐	☐
Cochlear/other ear implant or hearing aids, removable dentures	☐	☐
Artificial/prosthetic limbs, plates, rods, screws, wires or nails	☐	☐
Shunts – either spinal or intraventricular (programmable/non-programmable?)	☐	☐
Gastric band/sleeve, capsule/swallow camera, gastric reflux device	☐	☐
Any other surgery / any other medical implants e.g. RFID chip/tag, insulin pump, tissue expander, transvenous pacing leads, Swan-Ganz catheter, Libre/other diabetic monitor	☐	☐
Renal impairment/kidney problems	☐	☐
Metal fragments or foreign bodies - especially in the eyes even if long ago	☐	☐
Any tattoos or ear/other body piercings	☐	☐
Any previous experience of MRI at Torbay or elsewhere	☐	☐
Could you be pregnant?	☐	☐
Do you have diabetes? Yes / No	Do you have asthma? Yes / No	

For some patients an injection of contrast dye may be necessary for the MRI examination to be fully diagnostic
If so, information will be shared about the risks and benefits

Please tick to confirm you're happy with the information supplied and consent to having contrast	Yes	No	N/A
	☐	☐	☐

- You may be asked to change into a hospital gown/remove clothing with metallic fasteners or threads
- Personal belongings including wallets, keys, watches, jewellery & phones must be removed
- Loose metallic or electronic objects, including coins and bank cards must be removed from pockets
- Glasses, hearing aids, and dentures with metallic plates or wires must be removed
- Metallic foil-backed medication patches or ECG tabs and coloured contact lens must be removed
- Metal ear/body piercings, metal hair/wig fasteners, and magnetic eyelashes must be removed
- For safety you will be given ear protection as the scanner is very noisy

Form completed by: ☐ Patient ☐ Relative ☐ Doctor ☐ Nurse ☐ Radiographer/RSW

PRINT NAME _____ SIGNATURE _____ DATE _____

Checked by: RSW Signature _____ Radiographer Signature _____

RADIOLOGICALLY GUIDED INJECTION CONSENT FORM

NERVE ROOT SHEATH INJECTION

The purpose of this document is to provide written information regarding the risks, benefits and alternatives to the nerve root sheath injection you have been referred for today. This is supplementary to the discussion you have already had with your clinical referrer. You **must** have tried all alternative therapies, treatments, exercises, and activity modifications before being referred for this appointment and they **must** have proven unsuccessful. It is important that you fully understand this information, so please read this document carefully.

BENEFITS
You may receive the benefit of pain relief and improved mobility following this procedure, but this cannot always be guaranteed. Please consider carefully if these potential benefits outweigh the risks. The World Health Organisation and many other medical societies have declared that steroid injections are not recommended during the global coronavirus (Covid-19) pandemic. Please bear this in mind when considering your decision to proceed with this treatment.
RISKS
Before undergoing the procedure, understanding the associated risks is essential. No procedure is risk-free. The following risks are well recognised, but there may also be risks that have not been included in this list that are unforeseen by the performing physician. • There may be allergic reactions to the medicines injected, to the tape or equipment used (such as latex), chemicals used to clean the skin, or an adverse interaction with your prescribed medication, for instance. This may be localised to the injection site or be a whole body response. You will be asked a series of safety questions prior to the procedure to minimise this risk. • There may be infection, although this is rare. You may develop ‘post-injection flare’ which is swelling and pain several hours after the corticosteroid injection. • There may be temporary or permanent nerve damage, although this is rare. Generally, more than two injections into the same site is discouraged. • Although extremely rare, the blood supply to the spine may be affected, particularly with L1 or L2 level injections. In addition, and once again extremely rare, a blood clot may form around or next to the nerve which may worsen your symptoms and require surgical removal. • There may be de-pigmentation (a whitening) of the skin. • There may be local fat atrophy (thinning of the skin) at the injection site • There may be pain associated with this procedure and the healing process. • Injected steroids can reduce the function of the immune system for several weeks which means that there is a potentially increased risk of becoming infected with coronavirus (COVID-19) or other viruses. In a small proportion of patients that can lead to serious complications, including serious lung damage, which in the worst cases could require admission to an Intensive Care Unit (ICU/ITU) and ventilation and possibly death.
WARNINGS
• Female patients may experience heavier menstrual periods than normal related to a hormonal response to the steroid. • There may be a sensation of flushing of the face, neck and upper chest (this may occur up to a few days after the procedure) • You should refrain from driving until the following day. • The injection may trigger your pain temporarily. Normally this subsides shortly after the procedure. However, you may experience a flare up of symptoms prior to the medication taking effect. The duration and onset of pain relief is variable. • You may experience a feeling of a “dead leg”, with associated numbness or tingling. • You must seek advice from your GP or medical prescriber prior to adjusting your prescribed medication, following the procedure. • If you feel flu-like or feverish symptoms; or a redness or pain around the injection site within the first week after the injection, you should seek advice from your GP or walk in centre (during opening hours); or emergency department (out of hours)
ALTERNATIVES
• You may wish to make an appointment with the doctor or healthcare professional who referred you for this treatment to discuss your treatment options and to consider repeating alternative therapies. • Do nothing. The procedure is performed at your discretion. If your symptoms have improved since the referral was made, please inform the performing physician.

PROCEDURAL CHECKLIST		YES	NO
Allergies If yes , please state:			
Anti-coagulants (blood thinning medication) If yes , state the name of the medication:	<i>Practitioner use only:</i> If prescribed Warfarin, INR..... Date taken.....* *Use Coaguchek if not day before Date stopped: Warfarin: INR < 1.5 (restart in 12 hours) Clopidogrel: Stop for 7 days (restart in 6 hours) Rivaroxaban: eGFR > 30 (Stop for 18 hours; restart 6 hrs) eGFR < 30 (Stop for 48 hours; restart 6 hrs) Apixaban: Stop for 24 – 48 hours (restart in 6 hours) Dabigatran: eGFR > 80 (Stop for 48 hrs; restart in 6 hrs) eGFR 50 – 80 (Stop for 72 hrs; restart 6 hrs) eGFR 30 – 50 (Stop for 96 hrs; restart 6 hrs) Aspirin: Continue taking		
Anti-smoking medication (Zyban)			
Anti-retroviral medication (a treatment for HIV)			
Diabetes			
Someone to drive home			
Pregnant			
Breast feeding			
I can confirm that I have tried all alternative therapies, treatments, exercises, and activity modifications before being referred for this appointment and they have not been successful in treating my pain.			
I can confirm that I do not have symptoms of a viral illness, such as Covid-19. I do not have a high temperature, a new (continuous) cough, or a loss or change to my sense of smell or taste.			
I can confirm that I will socially distance and wear a face mask in enclosed public spaces for a further 14 days after this injection as I will be temporarily immunosuppressed and at greater risk of contracting and fighting coronavirus, which may have fatal consequences (as described <u>overleaf</u>)			
I can confirm that I have not received a Covid-19 or Flu vaccination within the last two weeks or have one booked within the next two weeks.			

CONSENT TO THE PROCEDURE:

Please sign the form below once you have read and understood the information provided overleaf. By signing this form, you have agreed to proceed with treatment considering the information and possibility of complications, as detailed.

Patient name.....

Site and laterality to be injected..... (e.g. right L5)

Site confirmed with patient ☐ (Place a tick ✓ in the box)

I consent to the injection procedure, have read and understood the information overleaf and have provided accurate details for the procedural checklist. I am in agreement with the site to be injected today. I understand the alternatives to this treatment and have been provided the opportunity to refuse the procedure. I have made this decision by myself and have not been influenced by anyone in the process of reaching this conclusion to proceed. I have understood the possibility of the risks and complications as detailed, which could have fatal consequences, and am happy to accept this and consent to the procedure. I will adhere to the post injection requirements for 14 days as outlined above.

Signature of patient..... Date.....

I have checked the information on this form with the patient and have also provided additional verbal information and explanation, personalised to the patient, until they have confirmed to me that they are happy for me to proceed with the injection into the above named site.

Signature of performing physician.....Date.....

Pregnancy Consent Form

X-rays during pregnancy do not increase the risk of miscarriage or cause problems in the unborn baby, such as birth defects and physical or mental development problems.

However, if a pregnant patient has an x-ray and is exposed to radiation there is a very small increased risk that the baby may go on to develop cancer in childhood. This is why the dose of radiation used in an x-ray is always as low as possible.

If you are having an examination on anything other than your abdomen or pelvis, your foetus won't be directly exposed to any radiation and the increased risk is negligible.

If the area we are investigating is in your abdomen or pelvis, your foetus will be exposed. The decision has been made by your doctor and the radiology staff that any risk to your foetus from having the examination, is less than the risk to you of not having the examination.

Name		Date of Birth	
First line of address			
Investigation		Number of weeks pregnant	
Declaration by Patient			
I have read and understood the information above and give my consent for the examination.			
Signed		Date	

X Ray Consent Form

You have been referred for a diagnostic or interventional procedure which involves the use of ionising radiation. In proceeding with imaging, Radiology consider the risk of NOT performing an exam that includes missing a diagnosis and/or initiating treatment too late to improve the medical outcome. As Radiographers it is our professional duty and legal responsibility to ensure that we protect individuals from unnecessary exposures to radiation.

We use this form for examinations which we have determined are of relatively greater risk. We do not ask for examinations of negligible risk where the radiation received is equivalent to a single day's normal background radiation. The risk is still very low for the examinations with greater risk, but it is equivalent to 73-91 days background radiation. A copy of this document will be stored electronically with your Radiology attendance details, following all appropriate Data Protection guidelines.

Please answer all the following questions, this information is necessary for us to be able to proceed with your examination. Thank you for your cooperation.

Patient Identification

Name		Date of Birth	
First line of address			

Height and Weight

This data helps us optimise our radiation exposures. Please circle units as appropriate.

Height		cm	m	feet and inches
Weight		kg	stone and pounds	

Pregnancy

This data helps us ensure any developing foetuses are kept safe as they are at a substantially greater risk from ionising radiation. We ask this question of all patients having abdominal/pelvic studies from 12 years old until their 55th birthday, irrespective of registered gender. Regardless of pregnancy these examinations also cover the bodies more radiosensitive organs.

I am (please tick) ☐ NOT pregnant ☐ possibly pregnant* ☐ Pregnant*

*Depending on the answer to the above question we may need to discuss this further with you and/or your referring practitioner.

We are an open and inclusive department and if you wish to discuss any of this further then we hope you feel able to do so.

Consent

Please sign and date to indicate consent is given for this examination and that you understand the radiation risk involved and reasons why this examination has been requested by your referring practitioner.

Signature		Date	
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Radiographer Signature on Behalf of Patient

The patient is unable to complete the form independently but has the capacity to understand the form and consent to the test. Form filled out on patient's behalf. Verbal consent has been obtained.

Radiographer name (print)			
Signature		Date	

Directorate of Radiology,
Torbay District General Hospital,
Lawes Bridge,
Torquay TQ2 7AA

Direct Line: 01803 654640

Dear Patient

Your steroid injection appointment in Radiology

You have been referred for a pain relief injection in Radiology using a corticosteroid substance. In the current COVID-19 pandemic this could, in theory, present a risk to you. There is concern that steroids can increase your risk of getting coronavirus as well as make the illness more severe.

Unfortunately, these effects are poorly understood for coronavirus because of the novel nature of the infection and the lack of research into it, but we do know that coronavirus can result in becoming seriously unwell if contracted. These concerns are based on knowledge that steroids can reduce the ability of the body to fight infection for a short period. In a small proportion of patients that can lead to serious complications, including serious lung damage, which in the worst cases could require hospital admission, ventilation (a machine to help you breathe), and possibly death.

It is important that you are made aware of this and the process you will be required to follow after your appointment. This information will allow you to make an informed decision as to whether you still wish to proceed with a steroid injection.

There is not a requirement to have a Polymerase Chain Reaction (PCR) swab test prior to your procedure, but due to the increased risks associated with receiving a steroid injection, we advise that you follow the social distancing rules and wear a face covering in enclosed public spaces for two weeks before **and** after the injection.

We also ask that you do not have a COVID-19 immunisation booster for two weeks before **and** after your steroid injection. This is because steroids can reduce the effectiveness of the booster and may result in it not working to protect you.

If you do choose to attend, the Clinician carrying out the procedure will discuss this more fully and ask you for your consent to proceed.

You **must** postpone the injection if you have any symptoms of viral illness, including those that could be related to COVID-19 or cold or flu. This will include a high temperature, a new continuous cough, or a loss or change to your sense of smell or taste.

Please contact Radiology on **01803 654640** if you have any of these symptoms prior to your appointment and **do not attend**. Your appointment will be prioritised once you are feeling better and able to have the injection.

Thank you,

The Musculoskeletal Intervention Team (Radiology)

CT Scanning Patient Checklist

Name			
Address			
Date of Birth		Preferred Pronouns	☐ He/Him ☐ She/Her ☐ They/Them ☐ Prefer not to say ☐ Other:
Height		Weight	

Please **CIRCLE** either **YES** or **NO** for the following questions

Do you have any allergies ?	Y	N
Do you have Asthma ?	Y	N
Do you have any kidney/renal problems ?	Y	N
Do you take Metformin ?	Y	N
Have you had a CT scan in the last three months?	Y	N
Have you had an injection of x-ray dye before?	Y	N
If YES did it cause you any problems?	Y	N
Have you drunk all of the preparation if asked to do so in your appointment letter?	Y	N

Please remove any metal, such as necklaces, earrings etc. from the area to be scanned

Staff Only

Checked By

Patient Declarations - To be completed with a member of RADIOLOGY staff.

The procedure for which you are attending uses ionising radiation. Regulations called IR(ME)R 2017 require us to establish the possibility of pregnancy in all patients between the ages of 12-55 who have potential to become pregnant. This includes Women and People with a Uterus. I DECLARE THAT I AM ☐ NOT PREGNANT ☐ POSSIBLY PREGNANT ¹ ☐ DEFINITELY PREGNANT ¹	
Radiographer – Is this a High or Low Dose examination? ☐ HIGH – LMP within last 10 days? ☐ LOW – Period Overdue?	Patient's Signature (Parent or Guardian if under 16 and not Gillick competent ²)
I confirm that these answers are true and accurate to the best of my knowledge. I understand the examination I am about to have. I CONSENT TO THIS EXAMINATION.	Patient's Signature (Parent or Guardian if under 16 and not Gillick competent ²)
I understand that I may need an intravenous injection of a contrast agent for my scan. I confirm that the risks and benefits of the cannulation and injection have been explained to me and I understand them. I CONSENT TO HAVING A CANNULA INSERTED AND THE INJECTION OF CONTRAST.	Patient's Signature (Parent or Guardian if under 16 and not Gillick competent ²)

1. If possible or confirmed pregnancy, the 'Radiology SOP4 – Radiological Examination of Patients of Reproductive Capacity' must be referred to, using the declaration form contained within the appendices.
2. Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.

STAFF USE ONLY

Contrast administered under direction of PGD numbers 2504, 2505, 2506 and 2507

EXAMINATION TO BE PERFORMED	
DATE AND TYPE OF PREVIOUS CT SCAN	
ARE ANY CT SCANS DUE?	YES / NO
eGFR	
VENLON INSERTED SIZE/POSITION	
ANY FAILED ATTEMPTS?	YES / NO
IF YES SIZE/POSITION OF ATTEMPTS	

April 2023 - V2.0

DLP (mGy^{cm}³):

CT Scanning Patient Checklist

CT COLONOSCOPY – To be completed by Radiographer

Below are the contra-indications for giving Hyoscine Butylbromide (Buscopan) as stated on the professional leaflet supplied by Boehringer Ingelheim. Hyoscine Butylbromide (Buscopan) administered under PGD number 1667

Narrow angle glaucoma	YES / NO
Tachycardia/ AF/ Angina	YES / NO
Myasthenia gravis	YES / NO
Megacolon	YES / NO
Stenosis in the region of the gastrointestinal tract	YES / NO
Paralytic Ileus	YES / NO
Prostatic enlargement with urinary retention (if applicable)	YES / NO

**I have been made aware of the risks of this examination including perforation.
I CONSENT TO INSUFFLATION.**

Patient's Signature (Parent or Guardian
if under 16 and not Gillick competent ²)

**Was Hyoscine
Butylbromide
(Buscopan) given?**

Y/N

Authorised by:

**Administered by Radiographer
(under PGD Number 1667)**

Signature:

Date Given:

**Dose/Volume
Given (mg/ml)**

**Batch
Number**

**Expiry
Date**

CT CARDIAC IMAGING

HEART RATE

BP

BMI

RADIOLOGIST
PRESCRIPTION

SIGNATURE

DATE

TIME

SUPPORT WORKERS

Have you attached all 5 ECG
Tabs?

YES

NO

Metallic objects removed where
required?

YES

NO

Patient information about

DaTSCAN

A DaTSCAN is used to look at the function of one particular part of your brain.

You will be given some tablets to take when you first arrive in the department. One hour after you have taken these tablets, a special liquid called a radioactive tracer will be injected into a vein in your arm. This enables us to obtain images of your brain when we scan you. The radiation dose you will receive is the equivalent of 291 days of background radiation when living in Devon. This is classed as a low risk procedure, but has been deemed beneficial to your diagnosis by your referring doctor. The injection takes at least 3 hours to be taken up into your brain. When you have your injection, you will be given a time to come back for your scan. During your scan we will ask you to lie flat on an imaging table for approximately 45 minutes.

Important Instructions

- As you will be given a radioactive injection, please avoid **close prolonged contact** with pregnant women or children for 48 hours after your injection
- When in the department please only use the Nuclear Medicine toilet. Once further on from the chapel, any toilets within the rest of the hospital may be used
- You can leave the department between your injection and scan if you wish
- You will be asked to wear a yellow wristband for the next week to identify to other healthcare staff that you are radioactive

Consent:

- ☐ I have read the above information
- ☐ I consent to having the radioactive injection
- ☐ I am not pregnant or breastfeeding

Weight:.....Height:.....

Name:.....

Signed:.....Date:.....

Do you have any of the following:

	Yes	No
Thyroid issues		
Dermatitis herpetiformis		
Kidney issues		
Adrenal gland issues		
Extreme dehydration		

Above discussed with staff member:

Staff signature:.....

Date:.....

MRI SAFETY QUESTIONNAIRE

Patient Name _____ Daytime Tel. No. _____

Date of Birth _____ Weight _____ Height _____ Occupation _____

Please indicate if you have, or have ever had, any of the following: **Yes** **No**

Cerebral aneurysm clips or any other brain surgery ☐ ☐

Cardiac pacemaker, heart valves or any other heart/chest surgery ☐ ☐

Electronic, mechanical or magnetically activated implants/devices ☐ ☐

Brain/spinal neuro-stimulators ☐ ☐

Cochlear/other ear implant or hearing aids, removable dentures ☐ ☐

Artificial/prosthetic limbs, plates, screws, wires or nails ☐ ☐

Shunts – either spinal or intraventricular (especially programmable) ☐ ☐

Renal impairment/kidney problems ☐ ☐

Any other surgery whatsoever ☐ ☐

Gastric band, capsule/swallow camera, gastric reflux device ☐ ☐

Any other devices/implants ☐ ☐
e.g. RFID chip or tag, triggerfish contact lens, implanted or external insulin pump,
temporary transvenous pacing leads, Swan-Ganz catheter, tissue expander

Any metal fragments or foreign bodies - especially in your eyes ☐ ☐
for which you sought medical attention, even if long ago

Any tattoos or ear/body piercings ☐ ☐

Any previous experience of MRI ☐ ☐

Could you be pregnant? ☐ ☐

Are you breast feeding? ☐ ☐

- You may be asked to change into a hospital gown/remove clothing with metallic fasteners or threads
- Personal belongings such as coats, handbags, purses, wallets, keys, watches, jewellery, mobile phones must be placed in a secure locker or left on the ward
- Loose metallic or electronic objects, including coins and bank cards must be removed from pockets
- Glasses, hearing aids, and dentures with metallic plates or wires must be removed
- Metallic foil-backed medication patches or ECG tabs and coloured contact lens must be removed
- Metal ear and body piercings, hair fasteners and magnetic eyelashes must be removed
- For safety you will be given ear protection as the scanner is very noisy

Form completed by: ☐ Patient ☐ Relative ☐ Doctor ☐ Nurse ☐ Radiographer/RSW

PRINT NAME _____ SIGNATURE _____ DATE _____

Checked by: RSW Signature _____ Radiographer Signature _____

Contrast/Cannulation Details – Staff Use Only

Radiographer/RSW to complete

Patient Name _____ DoB _____ RA9 _____

eGFR & date of blood test, if applicable	
--	--

Location & size of cannula/venflon	
Cannula inserted by	
Multiple attempts - location/by whom	
Special considerations e.g. needlephobia /vasovagal	
Cannula removed by	
Any other comments	

Contrast type/lot/expiry date/dose	Clariscan ☐ Dotarem ☐ Gadovist ☐ Primovist ☐	Lot: Expiry: Qty:
Affix contrast sticker(s) here, if applicable		
Contrast administered by (Radiographer)		
Contrast double-checked by (Radiographer)		

Patient Agreement to Investigation or Treatment Form

(Please complete or attach label)

Hospital: Patient's Surname:.....

NHS Number: Other Names:
(or other identifier)

Date of Birth: Age..... Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site
Cardiac Catheterisation +/- Pressure wire study +/- Intravascular Imaging	

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in the consent policy)

I have explained the procedure to the patient. In particular: -

The intended benefits: -

- Help the doctor determine whether you have disease affecting your coronary arteries
- Help the doctor to determine if there is likely to be a cardiac cause for your symptoms
- Help the doctor to decide if you need, or are suitable for, any further heart procedures or treatments e.g. additional heart medications, coronary stents or heart bypass surgery

Serious or frequently occurring risks: -

On rare occasions, coronary angiogram may be associated with serious complications such as heart attack, stroke, or death. Serious complications of this procedure are rare (perhaps 1 in 700 tests), but it is not uncommon for there to be bruising or bleeding at the site of the catheter insertion after the procedure. Performing an additional pressure wire study and/or intravascular imaging may increase overall risk to 1:300.

Any extra procedures which may become necessary during the procedure including: -

☐ Blood Transfusion

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information has been provided: Torbay Hospital Angiogram Patient Information Sheet.

The procedure will involve a local anaesthetic +/- mild sedation.

Signed: Date:

Name (PRINT): Job Title:

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed..... Date:

Name (PRINT):

Top copy accepted by patient. Yes ☐ No ☐

Statement of Patient

1. Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I am the Patient	
I agree	To the procedure or course of treatment described on this form
I understand:	That you cannot give me a guarantee that a particular person will perform the procedure. The person will however have appropriate experience. That I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia). That any procedure in addition to any described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedure which I do not wish to be carried out without further discussion. 	
PATIENT Signature: Name (PRINT) Date: A witness should sign below if the patient is unable to sign but has indicated his/her consent. Young people/children able to themselves consent may also like a parent to sign here. Signature: Name (PRINT) Date:	

Confirmation of the consent (to be completed by medical staff or nurse when the patient is admitted for the procedure if the patient has signed the form in advance).

On behalf of the team treating the patient I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Signed: Date:

Name (PRINT): Job Title:

Important Notes (tick if applicable)

See also advance directive/living will (e.g. Jehovah Witness Form)

Patient has withdrawn consent: Patient Signature:..... Date

Patient Agreement to Investigation or Treatment Form

(Please complete or attach label)

Hospital: Patient's Surname:.....

NHS Number: Other Names:
(or other identifier)

Date of Birth: Age..... Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site
Cardiac Catheterisation +/- Pressure wire study +/- Intravascular Imaging	

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in the consent policy)

I have explained the procedure to the patient. In particular: -

The intended benefits: -

- Help the doctor determine whether you have disease affecting your coronary arteries
- Help the doctor to determine if there is likely to be a cardiac cause for your symptoms
- Help the doctor to decide if you need, or are suitable for, any further heart procedures or treatments e.g. additional heart medications, coronary stents or heart bypass surgery

Serious or frequently occurring risks: -

On rare occasions, coronary angiogram may be associated with serious complications such as heart attack, stroke, or death. Serious complications of this procedure are rare (perhaps 1 in 700 tests), but it is not uncommon for there to be bruising or bleeding at the site of the catheter insertion after the procedure. Performing an additional pressure wire study and/or intravascular imaging may increase overall risk to 1:300.

Any extra procedures which may become necessary during the procedure including: -

☐ Blood Transfusion

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information has been provided: Torbay Hospital Angiogram Patient Information Sheet.

The procedure will involve a local anaesthetic +/- mild sedation.

Signed: Date:

Name (PRINT): Job Title:

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed..... Date:

Name (PRINT):

Top copy accepted by patient. Yes ☐ No ☐

Please tear off this section (pages 3 and 4) and give to the patient.

Information to be kept by Patient

You, or the Doctor, may use this space for written notes or drawings

What is it?

Cardiac catheterisation uses X-rays to obtain information about the heart including the heart arteries, the heart muscle and the heart valves. It may be referred to as coronary angiography when the test is principally directed at finding information about the heart arteries. This is the most common reason for this procedure.

Narrowing in the heart arteries restricts the blood supply to the heart muscle, and this may cause chest pain or discomfort (angina). A sudden blockage in a heart artery may cause a heart attack and damage the heart muscle. Coronary angiography allows your doctor to see whether you have narrowing in the heart arteries, and if so, decide with you how best to treat this. Options include tablets. Balloon angioplasty (stretching an artery from inside) and coronary artery bypass surgery.

The test is done in a special room in the X-ray department. After freezing the skin at the top of the leg (or in some cases the arm), a fine tube(s) is introduced into a blood vessel. This is used to put dye into the heart, and to measure within the heart and blood vessels. The patient lies under an X-ray camera, and the test usually takes 20-30 minutes.

What will I feel?

Most people do not find the test too unpleasant. You will not be aware of the tube inside you, although you may get some extra heartbeats. Once or twice during the test you will get a hot flushing sensation caused by the dye used to take the pictures. A few people get some brief discomfort as the dye is put in.

What happens afterwards?

When the test is finished the tube is removed and the hole is sealed by pressure. Unless the test is done from the arm you will not have any stitches. To make sure the hole seals properly you will be required to rest in bed for 4 hours. During this time you will get the results of your test.

Are there any risks?

The most common problem is bruising (or sometimes a lump which slowly disperses) around the hole at the top of the leg. Serious complications (including heart attacks and very uncommonly strokes) are rare and tend to occur in patients who have the most threatening heart problems. (An often quoted figure for serious complications is 1 in 700 tests.) Rarely, damage at the entry site in the arm or leg will require a further procedure to repair the artery.

Consenting to Treatment – Information for Patients

Why We Need Your Consent

All patients have the right in law to refuse any suggested examination or treatment if they so wish (except in some rare and exceptional circumstances which your doctor will explain to you). This is a basic principle of healthcare.

Your Right to Information

You should receive enough information from the doctor, nurse or any other person treating you, to understand the proposed treatment, possible alternatives, and any substantial risks. Please use this information to decide whether or not to agree to treatment. If you decide to go ahead, you can change your mind at any time.

Many people find it difficult to ask doctors questions. Please remember that your doctor, nurse and other health professionals are all here to help you. They are willing to answer any questions that you may have. Before signing the consent form you should be satisfied that the doctor has given you all the information you require now but do feel free to ask further questions throughout your treatment.

Space is provided on this sheet for you to take your own notes. You should keep this tear off sheet for your own information.

Teaching & Further Training

Health Professionals cannot learn all they need to know from textbooks or lectures. Teaching students is an important part of South Devon Healthcare Trust's work, and we need your assistance with this. During the period of your treatment, you may be asked to consent to having students present. You have the right to refuse this, but we would be grateful if you would co-operate with us. A refusal will not affect your standard of care.

Confidentiality

We may use your health information to help to improve the health of the public generally and to help the NHS run efficiently. We will remove the personal details which will identify you whenever possible.

Feedback Procedure

If you are unhappy with any aspect of your treatment (the care received, information given, etc), then please raise this in the first instance with your doctor or nurse. If you are unable to resolve the issue to your satisfaction, or would like to speak to someone more independent, please contact the Patient Advice and Liaison Service (PALS). The service can be contacted on Freephone 0800 02 82 037. The Trust welcomes feedback about the service you have received and is committed to using this information to improve services.

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face to face discussions with the patient.

The law on consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk.consent)

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed', then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:-

- ☞ They are unable to comprehend and retain information material to the decision and/or
- ☞ They are unable to weigh and use this information in coming to a decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about serious or frequently occurring risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

Patient Agreement to Investigation or Treatment Form

(Please complete or attach label)

Hospital: Patient's Surname:

NHS Number: Other Names:
(or other identifier)

Date of Birth: Age: Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site
Coronary Angiogram +/- Coronary Angioplasty +/- Stent(s)	

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in the consent policy)

I have explained the procedure to the patient. In particular: -

The intended benefits: -

Establish coronary anatomy to plan treatment of heart arteries

Potential treatment to improve blood supply to the heart muscle and relieve angina.

Serious or frequently occurring risks: -

On rare occasions, coronary angioplasty may be associated with serious complications such as heart attack, stroke, or death. The risk of these complications is usually less than 1% but may be higher in some patients. Bleeding or bruising from the site of catheter insertion may occur. Angina can recur because of re-narrowing of a treated artery. This happens in around 5% of patients.

Any extra procedure which may become necessary during the procedure as an emergency including:-

- ☐ Blood Transfusion
- ☐ Insertion of intra-aortic balloon pump (aortic balloon to relieve pressure on heart)
- ☐ Pericardiocentesis (drainage of blood accumulation around the heart)
- ☐ Emergency heart bypass surgery (risk: 1 in 1000). This would be performed at Derriford Hospital, Plymouth following ambulance transfer.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information has been provided: Torbay Hospital Angioplasty Patient Information Sheet.

The procedure will involve a local anaesthetic +/- mild sedation.

Signed: Date:

Name (PRINT): Job Title:

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed: Date:

Name (PRINT):

Top copy accepted by patient. Yes ☐ No ☐

Statement of Patient

- Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I am the Patient	
I agree:	To the procedure or course of treatment described on this form
I understand:	That you cannot give me a guarantee that a particular person will perform the procedure. The person will however have appropriate experience. That I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia). That any procedure in addition to any described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedure which I do not wish to be carried out without further discussion. PATIENT Signature: Name (PRINT): Date: A witness should sign below if the patient is unable to sign but has indicated his/her consent. Young people/children may also like a parent to sign here. Signature: Name (PRINT) Date:	

Confirmation of the consent (to be completed by medical staff or nurse when the patient is admitted for the procedure if the patient has signed the form in advance).

On behalf of the team treating the patient I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Signed: Date:

Name (PRINT): Job Title:

Important Notes (tick if appropriate)

See also advance directive/living will (e.g. Jehovah Witness Form)

Patient has withdrawn consent: Patient Signature: Date

Patient Agreement to Investigation or Treatment Form

(Please complete or attach label)

Hospital: Patient's Surname:

NHS Number: Other Names:
(or other identifier)

Date of Birth: Age: Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site
Coronary Angiogram +/- Coronary Angioplasty +/- Stent(s)	

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The intended benefits: -

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Potential treatment to improve blood supply to the heart muscle and relieve angina.

Serious or frequently occurring risks: -

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- ☐ Pericardiocentesis (drainage of blood accumulation around the heart)
- ☐ Emergency heart bypass surgery (risk: 1 in 1000). This would be performed at Derriford Hospital, Plymouth following ambulance transfer.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information has been provided: Torbay Hospital Angioplasty Patient Information Sheet.

The procedure will involve a local anaesthetic +/- mild sedation.

Signed: Date:

Name (PRINT): Job Title:

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed: Date:

Name (PRINT):

Top copy accepted by patient. Yes ☐ No ☐



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We may use your health information to help to improve the health of the public generally and to help the NHS run efficiently. We will remove the personal details which will identify you whenever possible.

Feedback Procedure

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Please tear off this section (page 3 and 4) and give to the patient.

Information to be kept by Patient

You, or the Doctor, may use this space for written notes or drawings

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

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Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves unless the opposite is demonstrated. If a child under the age of 16 has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed', then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

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- They are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information in coming to a decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

Patient Agreement to Investigation or Treatment Form*(Please complete or attach label)*

Hospital: Patient's Surname:.....

NHS Number: Other Names:

(or other identifier)

Date of Birth: Age: Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional: Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site
Pacemaker Implantation Local Anaesthetic +/- Sedation	

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in the consent policy)

I have explained the procedure to the patient. In particular, I have explained

The intended benefits:-

A heart pacemaker prevents the heart from beating too slowly. A slow heartbeat can cause blackouts and may be dangerous.

Significant, unavoidable or frequently occurring risks:-

Rare problems include pacemaker infection (1 in 200), bleeding or excessive bruising around the pacemaker site, inadvertent lung puncture (1 in 100), lead displacement and disturbance of the heart rhythm.

Any extra procedures which may become necessary during the procedure:

- ☐ Blood Transfusion
☐ Other (Please specify);

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information leaflet/tape has been provided: Torbay Hospital Implantation of a Pacemaker Patient Information Sheet.

The procedure will involve an anaesthetic: General ☐ Local ☐ Sedation ☐ No anaesthetic ☐

Signed: Date:

Name (PRINT): Job Title:

Contact details (if patient wishes to discuss options later):

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed: Date:

Name (PRINT):

Top copy accepted by patient. Yes No ☐ ☐

Statement of Patient

1. Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I am the Patient	
I agree	To the procedure or course of treatment described on this form.
I understand:	That you cannot give me a guarantee that a particular person will perform the procedure. The person will however have appropriate experience. That I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia). That any procedure in addition to any described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedure which I do not wish to be carried out without further discussion. 	
PATIENT Signature: Name (PRINT) Date: A witness should sign below if the patient is unable to sign but has indicated his/her consent. Young people/children able to themselves consent may also like a parent to sign here.	
Signature: Name (PRINT) Date:	

Confirmation of the consent (to be completed medical staff or nurse when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Signed: Date:
Name (PRINT): Job Title:

Important Notes (tick if applicable)

See also advance directive/living will (e.g. Jehovah Witness Form)

Patient has withdrawn consent ☐ Patient signature: Date:

Patient Agreement to Investigation or Treatment Form (1)

(Please complete or attach label)

Hospital: Patient's Surname:

NHS Number: Other Names:
(or other identifier)

Date of Birth: Age: Sex: (Please tick) Male ☐ Female ☐

Responsible Health Professional Job Title:

Special requirements e.g. other language/other communication method:

Name of Proposed Procedure or Course of Treatment (include brief explanation if medical term not clear)	Site

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in the consent policy)

I have explained the procedure to the patient. In particular, I have explained

The intended benefits:-

Significant, unavoidable or frequently occurring risks:-

Any extra procedures which may become necessary during the procedure:-

- ☐ Blood Transfusion discussed (please tick)..... leaflet given(please tick).....
☐ Other (Please specify):

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of this patient.

The following information leaflet/tape has been provided:

The procedure will involve an anaesthetic: General/Regional ☐ Local ☐ Sedation ☐ No anaesthetic ☐

Signed: Date:

Name (PRINT): Job Title:

Contact details (if patient wishes to discuss options later):

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient and to the best of my ability and in a way in which I believe he/she can understand.

Signed..... Date:

Name (PRINT):

Top copy accepted by patient. Yes ☐ No ☐ (please ring)

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not you will be offered a copy now. If you have any further questions, do ask -we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

Confirmation of the consent (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Signed: Date:

Name (PRINT): Job Title:

A witness should sign below if the patient is unable to sign but has indicated his/her consent. Young people/children able to themselves consent may also like a parent to sign here.

Signature:.....Name (PRINT) Date:.....

Patient has withdrawn consent: ☐ Patient Signature Date:

Information to be kept by Patient

You, or the Doctor, may use this space for written notes or drawings

Please tear off this section (pages 3 and 4 and give to the patient)

Consenting to Treatment – Information for Patients

Why We Need Your Consent

All patients have the right in law to refuse any suggested examination or treatment if they so wish (except in some rare and exceptional circumstances which your doctor will explain to you). This is a basic principle of healthcare.

Your Right to Information

You should receive enough information from the doctor, nurse or any other person treating you, to understand the proposed treatment, possible alternatives and any substantial risks. Please use this information to decide whether or not to agree to treatment. If you decide to go ahead, you can change your mind at any time.

Many people find it difficult to ask doctors questions. Please remember that your doctor, nurse and other health professionals are all here to help you. They are willing to answer any questions that you may have. Before signing the consent form you should be satisfied that the doctor has given you all the information you require now, but do feel free to ask further questions throughout your treatment.

Space is provided on this sheet for you to take your own notes. You should keep this tear off sheet for your own information.

Teaching & Further Training

Health Professionals cannot learn all they need to know from text books or lectures. Teaching students is an important part of Torbay and South Devon Foundation Trust's work, and we need your assistance with this. During the period of your treatment, you may be asked to consent to having students present. You have the right to refuse this, but we would be grateful if you would co-operate with us. A refusal will not affect your standard of care. Likewise we may ask your consent to use anonymous tissue samples taken from you for teaching, training or research purposes. Again you do not have to consent to this but we would be grateful for your co-operation.

Confidentiality

We may use your health information to help to improve the health of the public generally and to help the NHS run efficiently. We will remove the personal details which will identify you whenever possible.

Feedback Procedure

If you are unhappy with any aspect of your treatment (the care received, information given, etc), then please raise this in the first instance with your doctor or nurse. If you are unable to resolve the issue to your satisfaction, or would like to speak to someone more independent, please contact the Patient Advice and Liaison Service (PALS). The service can be contacted on Freephone 0800 02 82 037. The Trust welcomes feedback about the service you have received and is committed to using this information to improve services.

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Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face to face discussions with the patient.

The law on consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at <http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=law+on+consent>).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated (please keep in mind the Mental Capacity Act, the test for capacity and Sections 2 and 3 of the Act.) If a child under the age of 16 has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed', then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- Understand information about the decision to be made
- Retain that information in their mind
- Use or weigh that information as part of the decision making process, or
- Communicate their decision by (talking, sign language or any other means).

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself, unless an individual has been appointed by the patient to take healthcare decision under a Lasting Power of Attorney or as a court appointed deputy.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about serious or frequently occurring risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

Pregnancy Override Form

Justification by Practitioner*

*To be answered by the Practitioner, if the patient is pregnant or pregnancy cannot be excluded. If the Practitioner is not on site, then the radiographer may sign on their behalf after a verbal discussion.

We the clinicians, having given due consideration to the risk/benefit relationship of the requested examination, deem it to be in the best interest of the patient and therefore the best interest of any unborn foetus assumed to be present, justify this exposure in accordance with IR(ME)R 2024.

In times when urgent imaging is considered time critical to prevent significant harm to the patient this form is not required, but the time critical nature of the imaging must be documented on the radiology request form. (CT Trauma)

Patient Name			
Patient DOB			
Patient Address			
Is the examination to proceed?	YES	NO	
Reason for proceeding			
Is the patient fully informed?	YES	NO	N/A
Radiologist name (print):			
Signature:		Date	
Radiographer name (print):		Signature:	

Patient Information about Renogram Scan

A renogram scan is to look at the function and drainage of your kidneys.

During your scan you will be asked to lie on a bed for approximately 30 minutes, and a technologist/ radiographer will give you a small radioactive injection into a vein in your arm. This will enable us to see your kidneys when you are being scanned. Images will be taken at the same time so it is important that you stay as still as possible. A second injection may be given to you to get your kidneys working to their maximum effort. This injection will make you want to urinate more during the day so it is important that you keep yourself well hydrated. The radiation dose you will receive is the equivalent of 37 days of background radiation when living in Devon. This is classed as a very low risk procedure, but has been deemed beneficial to your diagnosis by your referring doctor.

Important Instructions

- When you arrive in the department you will be asked to drink some water before your examination starts.
- You will be asked to drink plenty of fluid for the 24 hours following your injection
- As you will be given a radioactive injection, please avoid **close prolonged contact** with pregnant women or children for 48 hours after your injection
- When in the department please only use the Nuclear Medicine toilet. Once further on from the chapel, any toilets within the rest of the hospital may be used
- You will be asked to wear a yellow wristband for the next 48 hours to identify to other healthcare staff that you are radioactive

Consent:

- ☐ I have read the above information
- ☐ I consent to having the radioactive injection
- ☐ I am not pregnant or breastfeeding

Weight:.....Height:.....

Name:.....

Signed:.....Date:.....

Do you have any of the following:

	Yes	No
Currently on furosemide		
Allergy to furosemide		
Allergy to antibiotics (sulphonamides)		
Kidney failure		
Low potassium or sodium levels		
Low blood volume		

Above discussed with staff member:

Staff signature:.....

Date:.....