INFORMED CONSENT FOR THE PERFORMANCE OF SURGERY OF THE PARATHYROID GLANDS

IDENTIFICATION DETAILS

Name and surnames of the patient: History number:

Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION

I wish to be informed on my illness and the operation to be performed on me: Yes □ No □

I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE

The surgeon has explained to me that the procedure consists of the total or partial extirpation of (one or all of) the parathyroid glands. On certain occasions, if advisable and if the extirpation is complete, the possibility may be considered to perform a glandular autotransplant or cryopreservation. In some circumstances, depending on the localisation of the parathyroid glands, it may be necessary to extirpate part of the thyroid gland. In some infrequent cases, it is not possible to localise all the glands and a second operation is required.

There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, in order to provide me with the most appropriate treatment.

The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.

Barring my indications to the contrary, part of the tissues obtained may be used for scientific, though at no event for commercial purposes.

Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE

The surgeon has informed me that it is the aim of this procedure to avoid the problems that may be caused to my organism by an excessive growth of one or several parathyroid glands and to control the hormone levels and the possible adverse effect on other adjoining or distant organs.

ALTERNATIVES TO THE PROCEDURE

Although the hormonal alteration may possibly be kept in check by another undefined medical treatment, this is not so in respect of the excessive growth of the gland nor, as the case may be, possible complications caused to other nearby or distant organs. In my specific case, it has been considered that this is the most appropriate treatment and that no efficient alternative is available.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE

I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:

Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Transitory cramps and tingling sensations in the hands, which remit with treatment. Transitory alterations of the voice. Transitory alterations of the deglutition. Prolonged pain in the operated area.

Serious risks, though not frequent: significant hematomas in the neck. Permanent alterations of the voice. Permanent alterations of the parathyroids. Recidivism of the illness.

As a general rule, these complications are solved by medical treatment (drugs, serum, etc.), although they may require a second operation, mostly of an emergency nature, and very seldom require the performance of a tracheostomy. In exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:

This surgical procedure consists of the extirpation of the parathyroid gland(s) and, in some cases, the operation – extirpation entails the need to perform a medical treatment.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR THE PERFORMANCE OF SURGERY OF THE PARATHYROID GLANDS

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**OPERATION OF THE PARATHYROID GLANDS**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor — Signature of the patient

Mr. / Mrs. — Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient — Signature of the lawful attorney

Date:

INFORMED CONSENT FOR THE EXTIRPATION OF THE CYST OF THE THIROGLOSSAL DUCTUS

IDENTIFICATION DETAILS

Name and surnames of the patient: History number:

Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION

I wish to be informed on my illness and the operation to be performed on me: Yes □ No □

I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE

The surgeon has explained to me that, through an incision in the neck, the procedure aims at extirpating the entire thiroglossal ductus, which is a congenital defect formed by tissue of the thyroid gland during its embryonic development. Occasionally, its complete extirpation may require the extirpation of a portion of the hyoid bone.

There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, in order to provide me with the most appropriate treatment.

The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.

Barring my indications to the contrary, part of the tissues obtained may be used for scientific, though at no event for commercial purposes.

Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE

The surgeon has informed me that it is the aim of this procedure to avoid the problems that may arise if the said ductus is not removed, such as pain, suppuration, discomfort when swallowing, etc…

ALTERNATIVES TO THE PROCEDURE

In my specific case, it has been considered that this is the most appropriate treatment and that no efficient alternative is available.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE

I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:

Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Transitory alterations of the deglutition. Prolonged pain in the operated area.

Serious risks, though not frequent: significant hematomas in the neck. Reproduction of the cyst.

As a general rule, these complications are solved by medical treatment (drugs, serum, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR THE EXTIRPATION OF THE CYST OF THE THIROGLOSSAL DUCTUS

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**EXTIRPATION OF THE CYST OF THE THIROGLOSSAL DUCTUS**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor — Signature of the patient

Mr. / Mrs. — Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient — Signature of the lawful attorney

Date:

INFORMED CONSENT FOR THE BIOPSY-EXTIRPATION OF A CERVICAL TUMORATION

IDENTIFICATION DETAILS

Name and surnames of the patient: History number:

Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION

I wish to be informed on my illness and the operation to be performed on me: Yes □ No □

I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE

The surgeon has explained to me that it is the aim of this procedure to take a sample or, if possible, to extirpate the tumoration existing in my neck. This will be done by means of a small incision in the neck, normally on the tumoration.

In certain selected cases, this surgical procedure can be performed under the system of CMA (Major Ambulatory Surgery), allowing for the patient to be discharged on the same day of the operation.

There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, in order to provide me with the most appropriate treatment.

The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.

Barring my indications to the contrary, part of the tissues obtained may be used for scientific, though at no event for commercial purposes.

Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE

The surgeon has informed me that it is the aim of this procedure to perform an anatomopathological study in order to diagnose the cause of the said tumoration with a view to facilitating a possible treatment.

ALTERNATIVES TO THE PROCEDURE

Although the hormonal alteration may possibly be kept in check by another undefined medical treatment, this is not so in respect of the excessive growth of the gland nor, as the case may be, possible complications caused to other nearby or distant organs. In my specific case, it has been considered that this is the most appropriate treatment and that no efficient alternative is available.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE

I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:

Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Transitory alterations of the voice. Transitory alterations of the deglutition. Phlebitis. Prolonged pain in the operated area.

Serious risks, though not frequent: significant hematomas in the neck. Permanent alterations of the voice. Serious infection in the neck. Recidivism of the illness.

As a general rule, these complications are solved by medical treatment (drugs, serum, etc.), although they may require a second operation, mostly of an emergency nature, and, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR THE BIOPSY-EXTIRPATION OF A CERVICAL TUMORATION

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**BIOPSY-EXTIRPATION OF A CERVICAL TUMORATION**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor
Mr. / Mrs.

Signature of the patient
Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient

Signature of the lawful attorney

Date:

INFORMED CONSENT FOR RADICAL MASTECTOMY

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that this procedure consists of the extirpation of the breast and the ganglions of the axilla of the same side. On occasions, the procedure will also involve the extirpation of the minor pectoral muscle and, less frequently, the major pectoral muscle.
On certain occasions, a device may be installed in the operated area that will facilitate the subsequent aesthetic reconstruction. Sometimes, if advisable, an immediate reconstruction may be carried out with a view to improving the aesthetic results.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all events with a view to providing me with the most appropriate treatment.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, but at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate the diseased breast in order to avoid its extension to the surrounding and distant tissues.

ALTERNATIVES TO THE PROCEDURE
In your specific case, it has been considered that this is the most efficient option. If the surgical resection is not accepted, in certain instances palliative treatments with chemotherapy, radiotherapy, hormonotherapy or a combination of the above may be considered.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Transitory arm edema. Alterations of the sensibility around the wound. Prolonged pain in the operated area.
Serious risks, though not frequent: serious inflammation of the lymphatic vessels of the arm. Reproduction of the disease. Serious bleeding. Impaired mobility of the shoulder and arm due to a lesion of the nerves of the region.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:
The extirpation of the entire breast results in an alteration of the anatomy of the area.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR RADICAL MASTECTOMY

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**RADICAL MASTECTOMY**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor
Mr. / Mrs.

Signature of the patient
Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient

Signature of the lawful attorney

Date:

INFORMED CONSENT FOR SUBCUTANEOUS MASTECTOMY

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that the procedure consists of the total or partial extirpation of the breast tissue, conserving the skin and, on occasions, the area of the areola – nipple.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all event with a view to providing me with the most appropriate treatment.
On certain occasions, when advisable, a device may be installed in the operated area that will facilitate the subsequent aesthetic reconstruction.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, though at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate the entire breast tissue or a major part of it, in order to avoid the risk of future diseases or to reduce their seriousness.

ALTERNATIVES TO THE PROCEDURE
In your specific case and at this moment in time, this is considered to be the most efficient alternative.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Alterations of the sensibility around the wound. Alterations of the anatomy of the breast. Prolonged pain in the operated area.
Serious risks, though not frequent: reproduction of the disease. Serious bleeding. Necrosis of the skin and the region of the areola - nipple.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.
Transitory cramps and tingling sensations in the hands, which remit with treatment. Transitory alterations of the voice. Transitory alterations of the deglutition. Prolonged pain in the operated area.
Serious risks, though not frequent: significant hematomas in the neck. Permanent alterations of the voice. Permanent alterations of the parathyroids. Recidivism of the illness.
As a general rule, these complications are solved by medical treatment (drugs, serum, etc.), although they may require a second operation, mostly of an emergency nature, and very seldom require the performance of a tracheostomy. In exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:
In some cases, an alteration of the anatomy of the breast occurs.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR SUBCUTANEOUS MASTECTOMY

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**SUBCUTANEOUS MASTECTOMY**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor — Signature of the patient

Mr. / Mrs. — Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient — Signature of the lawful attorney

Date:

INFORMED CONSENT FOR CONSERVATIVE BREAST SURGERY

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that this procedure consists of the extirpation of the breast lesion together with a margin of healthy tissue and the ganglions of the axilla of the same side. During the operation, an anatomopathological study will be performed to assess the extent to which the resection margins have been affected; consequently, if they are affected by the disease, it may be necessary to extirpate the entire breast during the same operation or at a later date (in another operation) in view of the results of subsequent examinations.
On certain occasions when the entire breast has been extirpated, a device may be installed in the operated area that will facilitate the subsequent aesthetic reconstruction.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all events with a view to providing me with the most appropriate treatment.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, but at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate my lesion in order to avoid its extension to the surrounding and distant tissues.

ALTERNATIVES TO THE PROCEDURE
In your specific case, it has been considered that this is the most efficient option. An alternative is the extirpation of the entire breast. If the surgical resection is not accepted, in certain instances palliative treatments with chemotherapy, radiotherapy, hormonotherapy or a combination of the above may be considered.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Transitory arm edema. Alterations of the sensibility around the wound. Prolonged pain in the operated area and transitory impairment of the mobility of the arm.
Serious risks, though not frequent: serious inflammation of the lymphatic vessels of the arm. Serious bleeding. Impaired mobility of the shoulder and arm. Reproduction of the disease.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:
In some cases there occurs an alteration of the anatomy of the breast.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR CONSERVATIVE BREAST SURGERY

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**CONSERVATIVE BREAST SURGERY**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor
Mr. / Mrs.

Signature of the patient
Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient

Signature of the lawful attorney

Date:

INFORMED CONSENT FOR BREAST TUMORECTOMY

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that this procedure consists of the extirpation of the breast lesion. The result of the anatomopathological analysis during or after the operation may indicate the necessity to extend the resection to the ganglions of the axilla and / or the entire breast or part of it.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all times with a view to providing me with the most appropriate treatment.
On certain occasions when the entire breast has been extirpated, a device may be installed in the operated area that will facilitate the subsequent aesthetic reconstruction.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, but at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate my lesion from the breast with a view to its anatomopathological study and in order to avoid its growth.

ALTERNATIVES TO THE PROCEDURE
In your specific case, given the need to carry out an accurate diagnosis, this is considered to be the most efficient alternative.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Transitory arm edema. Alterations of the sensibility around the wound. Prolonged pain in the operated area.
Serious risks, though not frequent: serious inflammation of the lymphatic vessels of the arm. Serious bleeding. Impaired mobility of the shoulder and arm. Reproduction of the disease.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:
In some cases there occurs an alteration of the anatomy of the breast.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR BREAST TUMORECTOMY

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**BREAST TUMORECTOMY**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor
Mr. / Mrs.

Signature of the patient
Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient

Signature of the lawful attorney

Date:

INFORMED CONSENT FOR BREAST BIOPSY WITH ANCHORAGE

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that it is the aim of this procedure to locate the existing lesion in the breast by radiological methods, marking the lesion with a harpoon in the x-ray department for its subsequent extirpation in the operating theatre and verification by radiographies that the resection has been complete.
The result of the anatomopathological analysis during or after the operation may indicate the necessity to extend the resection to the ganglions of the axilla and / or the entire breast or part of it.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all times with a view to providing me with the most appropriate treatment.
On certain occasions when the entire breast has been extirpated, a device may be installed in the operated area that will facilitate the subsequent aesthetic reconstruction.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, but at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate the lesion from my breast with a view to its anatomopathological study and in order to avoid its growth.

ALTERNATIVES TO THE PROCEDURE
In your specific case, given the need to carry out an accurate diagnosis and the impossibility to locate the lesion by other means, this is considered to be the most efficient alternative.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Transitory arm edema. Alterations of the sensibility around the wound. Reduction of the size of the breast. Prolonged pain in the operated area.
Serious risks, though not frequent: serious inflammation of the lymphatic vessels of the arm. Reproduction of the disease. Serious bleeding. Impaired mobility of the shoulder and arm.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:
In some cases there occurs an alteration of the anatomy of the breast.

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR BREAST BIOPSY WITH ANCHORAGE

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**BREAST BIOPSY WITH ANCHORAGE**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor
Mr. / Mrs.

Signature of the patient
Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient

Signature of the lawful attorney

Date:

INFORMED CONSENT FOR AXILLAR LYMPHADENECTOMY

IDENTIFICATION DETAILS
Name and surnames of the patient: History number:
Name and surnames of the lawful attorney (of relevant):

REQUEST FOR INFORMATION
I wish to be informed on my illness and the operation to be performed on me: Yes □ No □
I wish that the information on my illness and operation be provided to:

DESCRIPTION OF THE PROCEDURE
The surgeon has explained to me that this procedure consists of extirpating the lymphatic ganglions of the axilla with a view to performing a complete anatomopathological study.
There is a possibility that, during the operation, modifications may have to be made to the procedure in view of intra-operative findings, at all times with a view to providing me with the most appropriate treatment.
The procedure requires the administration of anaesthesia, the risks of which will be explained to me by the anaesthesiologist, and it is possible that the administration of blood or its derivatives may be required during or after the operation.
Barring my indications to the contrary, part of the tissues obtained may be used for scientific, but at no event for commercial purposes.
Barring my indications to the contrary, the performance of the procedure may be filmed for scientific or didactic purposes.

BENEFITS OF THE PROCEDURE
The surgeon has informed me that it is the aim of this procedure to extirpate the lymphatic ganglions of the axilla in order to carry out an exhaustive anatomopathological study, with a view to avoiding the extension of the disease to neighbouring or distant tissues.

ALTERNATIVES TO THE PROCEDURE
In your specific case, this is considered to be the most efficient alternative. If the surgical resection is not accepted, in certain instances palliative treatments with chemotherapy, radiotherapy, hormonotherapy or a combination of the above may be considered.

GENERAL AND SPECIFIC RISKS OF THE PROCEDURE
I understand that, in spite of the adequate selection of the technique and its correct performance, undesirable effects may arise, both the common ones deriving from any operation and liable to affect all organs and systems and others that are specific of this procedure, such as:
Risks of little consequence and frequency: infection, bleeding or alterations of the cicatrisation of the surgical wound. Accumulation of liquid in the wound. Phlebitis. Transitory arm edema. Alterations of the sensibility around the wound. Prolonged pain in the operated area.
Serious risks, though not frequent: serious inflammation of the lymphatic vessels of the arm. Reproduction of the disease. Serious bleeding. Impaired mobility of the shoulder and arm due to a lesion of the nerves in the region.
As a general rule, these complications are solved by medical treatment (drugs, serum, physiotherapy, etc.), although they may require a second operation, mostly of an emergency nature, while, in exceptional cases, they may be fatal.

PERSONALISED RISKS AND OTHER CIRCUMSTANCES:

CONSEQUENCES OF THE SURGERY:

DO YOU WISH TO MAKE ANY STATEMENT IN RELATION TO THE OPERATION?

INFORMED CONSENT FOR AXILLAR LYMPHADENECTOMY

Statements and signatures:

I, Mr. / Mrs. ……, holder of National Identity Document ……..,

- DECLARE: that the doctor has informed me previously and in a satisfactory manner with regard to the procedure (**AXILLAR LYMPHADENECTOMY**) to which I will be submitted, and on the risks and complications involved.
- That I know and assume the risks and / or consequences that may arise as a result of the surgical procedure as such, of the localisation of the lesion or of complications of the operation, in spite of the fact that the doctors have taken all precautions within their reach.
- That I have read and understand this document. I am satisfied with the information received, I have asked all questions I considered appropriate and all doubts raised have been clarified to me.
- That I have been informed of the possible use of the procedure in the framework of a teaching or research project without any additional risk for my health.
- I equally understand that I am entitled to revoke the consent granted hereby at any time and without having to give any explanation whatsoever, merely by informing the medical team.

Signature of the informing doctor — Signature of the patient

Mr. / Mrs. — Mr. / Mrs.

Associate number
Date

I, Mr. / Mrs. ……, holder of National Identity Document number ……, in my capacity as …….. due to ……..……, hereby grant my consent for the proposed procedure to be performed on him / her.

Signature of the lawful attorney

Date:

Revocation of the consent:

I, Mr. / Mrs. ……., holder of National Identity Document number …….,

REVOKE the consent previously granted for the performance of this procedure of my own free will, and assume the consequences deriving from such revocation with regard to the progress of the illness I suffer / the patient is suffering.

Signature of the patient — Signature of the lawful attorney

Date: