



SW9370



Queensland Government

## Slipped Upper Femoral Epiphysis Repair

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

### A. Interpreter / cultural needs

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

### B. Condition and treatment

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

.....  
 .....

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

.....  
 .....

Left thigh  Yes  No

Right thigh  Yes  No

The following will be performed:

A pin or screw is inserted across the growth plate at the upper end of the thigh bone to prevent any further slip of the growth plate.

### C. Risks of a slipped upper femoral epiphysis repair

There are risks and complications with this procedure. They include but are not limited to the following.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

### Specific risks:

- The pin may stick into the hip joint. This can cause damage to the hip joint and may require further surgery. Early arthritis may occur.
- The screw or pin may need to be removed. This will require further surgery.
- Pressure to various nerves from lying on the operating table particularly the nerves around the genital area leading to numbness of the scrotum. This may be temporary or permanent.
- Pressure on the skin around the genital region causing skin gangrene or death. This may require further surgery.

### D. Significant risks and procedure options

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

.....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....

### E. Risks of not having this procedure

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

.....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....

### F. Anaesthetic

This procedure may require an anaesthetic. *(Doctor to document type of anaesthetic discussed)*

.....  
 .....



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## G. Patient consent

I acknowledge that the doctor has explained;

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

**I have been given the following Patient Information Sheet/s:**

- About Your Anaesthetic OR
- Epidural & Spinal Anaesthesia
- Slipped Upper Femoral Epiphysis Repair

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

## I request to have the procedure

Name of Patient: .....

Signature: .....

Date: .....

### Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

Yes ▶ Location of the original or certified copy of the AHD: .....

No ▶ Name of Substitute Decision Maker/s: .....

Signature: .....

Relationship to patient: .....

Date: ..... PH No: .....

- Source of decision making authority (tick one):**
- Tribunal-appointed Guardian
  - Attorney/s for health matters under Enduring Power of Attorney or AHD
  - Statutory Health Attorney
  - If none of these, the Adult Guardian has provided consent. Ph 1300 QLD OAG (753 624)

## H. Doctor/delegate Statement

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

Name of Doctor/delegate: .....

Designation: .....

Signature: .....

Date: .....

## I. Interpreter's statement

I have given a sight translation in

.....  
*(state the patient's language here)* of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: .....

Signature: .....

Date: .....

DO NOT WRITE IN THIS BINDING MARGIN

