Responsible Health Professional……..

Title……

South Tees Hospitals NHS
NHS Foundation Trust

Patient details / label

Surname …….…….. First name ……..……..
Address ……
……
DoB …… D No. ……
NHS No ……..…… M ☐… F ☐

Consent Form 4

Name of Proposed Procedure or Course of Treatment

PERCUTANEOUS DILATATIONAL TRACHEOSTOMY

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

I have explained the procedure to the patient's next of kin. In particular, I have explained:

- **Purpose of percutaneous tracheostomy:**

To facilitate ventilation and weaning from mechanical ventilation, more comfortable airway, secretions management, other: ……

- **Complications of a tracheostomy:**
  - **Immediate complications (peri-operative)**

☐ Bleeding from damage of vessels in the neck (minor <5%, major <0.5%)
☐ Malposition of tracheostomy tube (0.5%)
☐ Significant deterioration in respiratory function / collapsed lung (2%)
☐ Pneumothorax or pneumomediastinum (air trapping) (<0.5%)
☐ Damage to the nerves in the neck (<1%)
☐ Death (<0.2%)

  - **Delayed complications**

☐ Tube blockage or displacement
☐ Infection and / or ulceration of stoma site
☐ Bleeding due to tube erosion of blood vessels or local tissue trauma

  - **Late complications**

☐ Significant scarring requiring revision
☐ Granulomata of the trachea
☐ Possible change in voice
☐ Tracheal stenosis (3-4%)

- **Any extra procedures which may become necessary following the procedure:**

☐ Blood Transfusion ☐ Emergency Surgery (for the complications stated above)

The following leaflet has been provided – Tracheostomy Patient Information Leaflet ☐
Special Requirements: e.g. communication, translator……

Signature ……..…… Date……..…..
Name (PRINT) ……..…….. Job title……..……
Signature ……..…… Date……..……
Name (PRINT) ……..…… Job title……..……
Signature ……..…… Date ……..……
Name (PRINT) ……..…… Relation to patient……
Verbal assent by phone from…… Relation to patient……

PERCUTANEOUS DILATATIONAL TRACHEOSTOMY

Patient details/label

Surname …….…….. First name ……..……...
Address ……
……..
DoB …… D No. ……
NHS No ……..…… M ☐… F ☐

Date……

Time…….

Location……...

Anaesthetist……
(Signature, GMC no, Print name and title)

Surgeon…...……...
(Signature, GMC no, Print name and title)

Supervising consultant…...……...
(Signature, GMC no, Print name and title)

Local anaesthetic……..

Sedation…….. Analgesia…….Relaxant……...

Throat pack used: ☐ Yes, if yes how many…….. ☐ No

Asepsis: Gown, Mask, Gloves, 2% Chlorhexidine / 70% Alcohol prep ☐

Technique: Landmark ☐ Ultrasound ☐ Direct bronchoscopy ☐

Incision……..

Trachea located, number of passes……..……

Tracheostomy set ……

Tracheostomy tube ……
……...
……...
……...

Tracheostomy set / tube sticker

☐ Instruments checked and returned

Comments……
……...……..……...
……..……
……..……

Difficulties and Complications
……
……
……...

Post Insertion CXR ☐ NO ☐ YES ……

If **Throat Pack** used: Removed ☐ Yes ……(number of throat packs removed)