

Responsible Health Professional.....

Title.....

**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

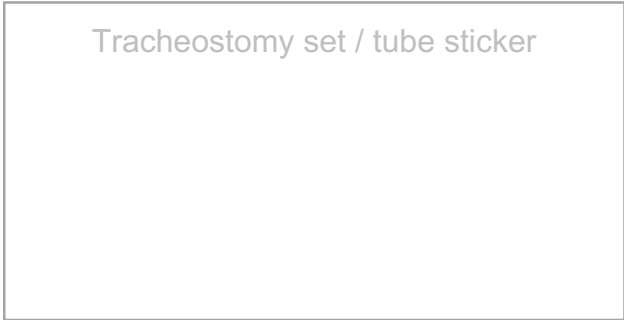
Technique: Landmark  Ultrasound  Direct bronchoscopy

Incision.....

Trachea located, number of passes.....

Tracheostomy set .....

Tracheostomy tube .....  
.....  
.....  
.....



Instruments checked and returned

Comments.....  
.....  
.....

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

Post Insertion CXR  NO  YES .....

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