



CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Patient Details

UR Number:

Surname:

Name:

Date of Birth: Gender:

Dr:

PART A: PROVISION OF INFORMATION TO PATIENT (To be completed by Medical Practitioner)

I, Doctor

have discussed with

(insert name of patient / parent / guardian)

the nature, likely results, and material risks of the recommended operation / procedure and/or treatment. I have also discussed the alternative treatments / procedures which are available.

The agreed operation / procedure / treatment is:

(Insert name of operation / procedure / treatment)

MBS Item Number(s):

- Left Side
- Right Side
- Not applicable

Will this procedure have a cosmetic portion? Yes No**Interpreter required?** Yes No

I,

(Name of interpreter)

have given a verbal translation of this form to consent to the treatment in the language that the patient understands,

which is:

Interpreter's Signature

Date

Medical Practitioner Signature

Date / /

Admission Date

/ / Time

Operation Date / /

PART B: PATIENT CONSENT (To be completed by Patient)

The treating doctor, whose name appears in Part A (above), and I have discussed my / my child's / my charge's present condition and the various ways in which it might be treated. The doctor has told me that:

- The operation / procedure / treatment carries some risks and complications may occur.
- Anaesthetics, medicines, and/or blood transfusion may be needed and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected.
- The procedure / treatment may not give the expected results even though the procedure / treatment will be performed with due professional care.
- Which alternative treatments / procedures are available.

I understand the nature of the procedure / treatment and that undergoing the procedure / treatment carries risks. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. I understand that I may withdraw my consent at any time prior to the procedure / treatment.

I **request, understand and consent** to the procedure / treatment as outlined in Part A. I agree to additional anaesthetics, medicines or procedures / treatments being carried out if required, provided they are related to the procedure / treatment outlined in Part A. I also consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV and Hepatitis B and C, should contamination of any staff member or myself occur during my hospital stay.

► Do you consent to a blood transfusion if needed? Yes No

Signature of Patient / Parent / Guardian

/ /

Date

Print name of Patient / Parent / Guardian

Signature of Witness of Signatory (adult person)

/ /

Date

Print name of Witness of Signatory



CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Attach patient identification label

UR Number:.....

Surname:.....

Name:.....

Date of Birth:..... Gender:.....

Dr:.....

Patient Details

CERTIFICATION OF INABILITY TO GIVE CONSENT FOR EMERGENCY PROCEDURES (To be completed by Medical Practitioner)

The undersigned registered medical practitioner certifies that

(Name of patient)

is incapable of giving effective consent by reason of

(State reason for inability to give consent, for example unconscious)

their Next of Kin is unable to give consent due to

(State reason for inability to give consent, for example uncontactable)

for the procedure(s) stated:

and that immediate treatment is necessary in order to avert a serious and imminent threat to the patient's life or physical or mental health.
I / We have no knowledge of any prior written refusal to consent to the procedure(s) having been communicated to any medical practitioner.

/ /

(Signature)

(Print Surname)

Date

/ /

(Signature)

(Print Surname)

Date

Second signature may not be available in extreme circumstances ie. second Medical Practitioner is not available

ADMISSION DETAILS (To be completed by Medical Practitioner)

Diagnosis

Proposed Admission Date:

/ /

Time (if known): : AM / PM

Proposed Procedure Date:

/ /

Time (if known): : AM / PM

Estimated Length of Stay:

Day Stay Overnight

HDU required Post-Op? *

Yes No

* If the service is provided by the hospital

ICU required Post-Op? *

Yes No

Pre Admission Clinic? *

Yes No

Referrals Required:

Special Instructions /
Past History

Medical Practitioner's Signature

Date

/ /

BINDING MARGIN – DO NOT WRITE IN THIS AREA

X

X