



Consent for Treatment

Family Name: _____ MR/UR No: _____
Given names: _____
Address: _____
Postcode: _____ DOB: _____
Treating Doctor: _____
(or place Patient Identification Label here)

I, Doctor Sonia Moorthy
(please print name of Visiting Medical Practitioner performing operation / procedure)

have discussed with _____
(please print name of patient / parent / guardian)

the patient's present condition, alternative treatments available, and explained the benefits and risks of the proposed operation/procedure. The proposed operation/procedure is:

Date to be attended: _____ at Buderim Private Hospital
(Date) (Hospital)

(Visiting Medical Practitioner's Signature) (Date)

I, _____
(please print name of patient / parent / guardian)
of _____
(Insert address of person requesting treatment)

request the above operation/procedure to be performed on me /upon

(Name of Patient)

I also request the administration of anaesthetics, medicines, blood transfusion or other forms of treatment normally associated with this operation/procedure.

I understand that other unexpected operations/procedures may be necessary and I request that these be carried out if required.

I understand that a sample of blood may need to be tested if there is an injury to either my doctor or a hospital employee during the proposed operation/procedure.

Although this operation/procedure will be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complication may occur with any operation/procedure, and I accept the possible risks associated with the operation/procedure.

I have had the opportunity to ask questions about the operation/procedure and I am satisfied with the information I have received.

(Signature of Patient / Guardian / Other) (Please print Name of Patient / Guardian / Other)

(Please print Relationship to Patient) (Date)