SUNSHINE COAST DAY SURGERY

Cnr Memorial & Second Avenues,
Maroochydore QLD 4558
Ph: (07) 5294 6516
scdreception@scds.net.au

(Affix identification label here)

URN: Best luck

Family name:

Given name(s): nice

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Operation/Procedure Consent

This consent form is to be used for adult or minor patients undergoing an operation or interventional procedure.

Information provided about the operation/procedure

I, Sonia Moorthy
(print name of Accredited Practitioner performing operation/procedure)
have discussed with
(print name of patient or, where the patient lacks capacity, the person who can legally make decisions on their behalf)
the patient's condition, care options (including the proposed operation/procedure), the material risks of the options and any risks that are specific to the patient, the benefits of the options, the expected outcome of the proposed operation/procedure and the expected outcome of not undergoing the operation/procedure.

The presenting symptoms or condition to be treated is:

The proposed operation/procedure is:

For ophthalmology procedures only

I authorise the following to be administered as per my preference sheet/pathway *(please tick)*:

☒ Eye drop regime ☒ Pre-operative/post-operative medication

Assessment of capacity to consent

I, Sonia Moorthy *(print name of Accredited Practitioner)* have assessed the capacity of the patient's ability to consent to the operation/procedure and have formed the view that:

☐ The patient **has** capacity to consent; *OR*

☐ The patient **does not have** capacity to consent, and so consent has been provided by the patient's:

(insert relevant legal basis, e.g. parent, legal guardian, enduring power of attorney, statutory health attorney)

Signature:
(Signature of Accredited Practitioner)

Date: / /

Consent to the operation/procedure

I,
(print name of patient, or where the patient lacks capacity, the person who can legally make decisions on their behalf)
request that the above operation/procedure be performed on:
(print name of patient).

By signing this form, I confirm that I have been advised (with the assistance of a translator, where that is necessary) and acknowledge that:

- I have been provided with sufficient information about my/the patient's condition, care options (including the proposed operation/procedure), the risks of the options and any risks that are specific to me/the patient, the benefits of the options, the expected outcome of the proposed operation/procedure and the expected outcome of not undergoing the operation/procedure;

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Operation/Procedure Consent

Consent to the operation/procedure *(continued)*

- I have had the opportunity to ask questions about the proposed operation/procedure and to read any information provided and I am satisfied with the information that I have received;
- the operation/procedure involves the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with the proposed operation/procedure;
- if a complication arises during the course of the proposed operation/procedure which requires urgent treatment to save my/the patient's life or prevent serious injury in circumstances where it is not practical to obtain consent, I/the patient will be provided with emergency treatment (which may include blood products) subject to the terms of any prior written and legally valid objection (including my/the patient's direction about the provision of blood below);
- a sample of my/the patient's blood may need to be taken and tested for infectious diseases if there is an injury to a doctor or staff member during the proposed operation/procedure;
- there is a risk that the proposed operation/procedure will not:
  - » for screening procedures: identify the condition being screened for; or
  - » for therapeutic procedures: improve my/the patient's condition or achieve an expected or desired outcome, despite it having been carried out with due professional care and responsibility;
- there are risks associated with the proposed operation/procedure, which may result in a worsening of my/the patient's condition or other adverse outcome for me/the patient and I accept these risks in requesting the proposed operation/procedure;
- images or video footage may be recorded as part of, and during, my/the patient's operation/procedure, and these images or videos will assist the doctor to provide appropriate treatment;
- I have the right to change my mind and withdraw my consent at any time before the operation/procedure, preferably after discussion with my/the patient's doctor.

Consent for anaesthetic/sedation

I consent to the use of anaesthetic or sedation as required to perform the operation/procedure.

Yes No

Consent for blood products

I consent to the use of blood products if they are required during my/the patient's operation/procedure.

Yes No

Signature: Umiya Patel

(signature of patient, or where the patient lacks capacity, the person who can legally make decisions on their behalf)

Name:

(print name of patient, or where the patient lacks capacity, the person who can legally make decisions on their behalf)

Relationship:

(relationship of the person who can legally make decisions for the patient and the patient, e.g. parent, legal guardian, enduring power of attorney, statutory health attorney as relevant in the state/territory where this form is signed)

Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

Cura CMR4.0 2/2 v1.00 10/03/2022