Healthe Care Australia

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Unit Record Number
Family Name ____________________
Given Names ____________________
Date of Birth   Age
Sex   Room No.

OR USE LABEL

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 of his / her present condition, the various ways of treating the patient's present condition and have explained the nature, purpose, likely results and the material risks of the following recommended procedure / treatment(s)

The agreed operation / procedure / treatment is:

(insert procedure / treatment — DO NOT use abbreviations)

MBS Item Number(s):

☐ Left Side ☐ Right Side ☐ Not applicable

Special Instructions:

Medical Practitioner Name

Medical Practitioner Signature

Date

Interpreter required? ☐ **Yes** ☐ **No**

I,

(Name of interpreter)

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

which is:

Interpreters Signature

Date

PART B: PATIENT CONSENT (To be completed by Patient) Patient or substitute decision maker if patient lacks capacity

The doctor whose name appears in Part A above and I have discussed my/patient's present condition and the various alternative ways in which it might be treated, including the above procedure or treatment. The doctor has told me that:

- The procedure/treatment carries some risks and that complications may occur and has provided details of those potential risks and complications;
- The administration of an anaesthetic, medicines and/or blood transfusions may be needed in association with this admission/procedure treatment(s) and that these carry risks;
- Additional procedures or treatments may be required in an emergency or if something unexpected is found requiring immediate management, and I agree to these additional procedures/treatments being carried out in these circumstances provided that they are related to the primary procedure set out in Part A;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with all due professional care.

I acknowledge that:

- I have been given the opportunity to ask questions of the doctor whose name appears in Part A and I understand the explanation that the doctor gave me as to the need, benefits, risks and complications related to this procedure/treatment(s).
- I have been advised of the material risks associated with this procedure/treatment(s) and the risks and benefits of any alternative treatments / procedures, including having no treatment.
- I have had an opportunity to ask questions and these have been answered in a way I understand by the doctor above. I am satisfied with the answers and the explanations to my questions.
- I understand that I have privately engaged my doctor and that my doctor is not an employee of the hospital
- I understand that I may withdraw my consent at any time before the procedure/treatment(s).
- I acknowledge that the procedure/treatment may involve the removal of some body tissue which may be required for the diagnosis and management of my / patients condition. I understand the tissue being removed is for the purposes of diagnosis or management of my / patients condition. I understand that consent only extends to tissue, which is removed for the purposes of the above procedure recorded in Part A.
- If a staff member is exposed to my blood or other bodily fluids, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

I request, understand and consent to the procedure and/or treatment as described and outlined above in Part A.
I also consent to anaesthetics and medicines that are to be given as part of the procedure / treatment outlines in Part A. I have received and understand information given to me about blood and blood products which may be needed by me to preserve my life or health in the course of the procedure / treatment.

▸ **Do you consent to a blood transfusion if needed?** ☐ **Yes** ☐ **No**

Signature of Patient / Parent / Guardian

Date

Print name of Patient / Parent / Guardian

DOCTOR TO COMPLETE WITH PATIENT

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

MR/53N

Print Media Group – HECZZFMR053N 09/17

Healthe Care Australia

Unit Record Number
Family Name ____
Given Names ____
Date of Birth ____ Age ____
Sex ____ Room No. ____

OR USE LABEL

REQUEST FOR ADMISSION

To ____________________ Hospital

To be completed by Doctor. Please PRINT clearly

REQUEST FOR ADMISSION

Mr, Ms, Mrs, Master: ______________________________
Surname Given Names

Address: ______________________________

Telephone: ______________________________ Date of Birth: ____________ Sex: ______
Home Business

ADMISSION DETAILS (To be completed by Medical Practitioner)

Provisional 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 Estimated Operating Time: _____ hrs _____ mins

ICU required Post-Op?* ☐ Yes ☐ No Type of Anaesthetic ☐ LA ☐ GA

Pre Admission Clinic?* ☐ Yes ☐ No * If the service is provided by the hospital

Referrals Required:

Special Admission Instructions / Past History / Allergies / Medications

Does this patient require Bariatric Equipment (BMI >35 OR weight >120kg) ☐ Yes ☐ No Weight _____Height ____ BMI ___

SPECIFIC PRE-OPERATIVE INSTRUCTIONS

☐ Anaesthetic Consultation
☐ Pre admission assessment
☐ Pathology tests required

☐ Investigations required

☐ Operating theatre advised (If "add on" or urgent case)
Date ______________ Time ______________
☐ Drug Orders on Admission (if possible please attach drug chart or detail below):

Specific equipment required

Medical Practitioner's Signature ***Date***

OBSTETRIC ADMISSIONS ONLY

Parity: ______________ EDC: _____/_____/_____ Blood Group: __________ Rh: ________ Hb: ________

Anti-D & agglut screen: ________________ Rubella HIA titre: __________ HBs Ag: ____________