SYDNEY PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

CONSENT TO SURGICAL OPERATION AND/OR PROCEDURE

ADMITTING DOCTOR:	DATE OF ADMISSION:	OPERATION DATE:	ESTIMATED LENGTH OF STAY

SURNAME	SEX ☐ MALE ☐ FEMALE	PARENT/GUARDIAN DETAILS (IF PATIENT UNDER 14 YEARS)
GIVEN NAME(S)		FULL NAME
ADDRESS		ADDRESS (IF DIFFERENT TO PATIENT)
		MOBILE NUMBER
D.O.B.	PHONE NUMBER	EMAIL
HEALTH FUND OR INSURANCE CO.	MEMBERSHIP OR CLAIM NO.	RELATIONSHIP TO PATIENT

PATIENT LABEL MUST BE ATTACHED

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RELEVANT INFECTIONS ☐ MRSA ☐ VRE ☐ HEP B or C ☐ HIV ☐ LA ☐ GA ☐ BLOCK ☐ NEURОLEPT

Dear Doctor, please fax this completed page immediately to hospital
Main OT - 9716 3513 NSW Eye Centre - 9716 3537

Known Allergies: ____________________

Provisional Diagnosis: ____________________

This consent is valid for the duration of your Surgical Admission

I ____________________

of ____________________

consent to the following/procedure ____________________

____________________ Item No.(s) ____________________

Prostheses Required / Instrumentation / Pre-op Instructions ____________________

____

____

be performed *upon me/upon ____________________

Following a discussion of *my/the patient's present condition, including the nature and likely results of the operation/procedure, I accept the professional opinion of Dr. ____________________ that this is the appropriate operation/procedure. Although this operation/procedure is carried out with all due care and responsibility, I understand that in some circumstances the expected result may not be achieved.

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

The possible complications, risks and benefits have been explained to me by Dr. ____________________

I also give consent to the taking of blood for appropriate testing of communicable diseases including HIV and Hepatitis, should contamination of any staff members, doctors, other person or myself occur during my hospital stay. The results will be communicated appropriately by the Infection Control Officer (ICO).

(✓) TICK APPLICABLE

Blood Transfusion/Products:

I understand why I may require a blood transfusion/product and have discussed other relevant options with the doctor. I have been informed of the risk and benefits, alternatives of a blood transfusion/product. I was given a Consumer Brochure.

☐ Yes, I consent to a blood transfusion/product

☐ No, I do not consent to a blood transfusion/product

Student Treatment:

I do ☐ or I do not ☐ consent to being treated by students in consultation with a Registered Nurse

Medical Company Representative:

I understand that it may be necessary to have a medical representative/visitor present during my surgery to provide technical support.

☐ Yes, I consent to a medical representative/visitor present

☐ No, I do not consent to a medical representative/visitor present

Pre-medication order: ____________________ given by: ____________________ Time: __________

DAY SURGERY/ENDOSCOPY PATIENTS ONLY

I understand that if I am discharged on the same day as my anaesthetic/sedation and my surgery/procedure, I should not drive a motor vehicle or operate machinery or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours.

I also understand that I must be accompanied home by a responsible adult.

____________________ SIGNATURE OF PATIENT/GUARDIAN/RELATIVE/ATTORNEY

____________________ DOCTOR'S SIGNATURE

____________________ DATE

BINDING MARGIN – DO NOT WRITE

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