



Ramsay Health Care

SURGICAL CONSENT FOR TREATMENT (PRIVATE)

URN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: _____

(Affix patient identification label here)

PART A - PROVISION OF INFORMATION TO THE PATIENT

To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED OR EMPLOYED PRACTITIONER

I have informed _____ and/or _____
PRINT NAME OF PATIENT

GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE)

RELATIONSHIP (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment: _____

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

- Side of procedure/treatment: Left Right Not Applicable
- I have explained to the patient that blood products/blood transfusions may be needed during or following the procedure. The potential risk and complications related to this have also been explained.
 Yes No Not Applicable
- The patient has consented to blood products/blood transfusions, if needed.
 Yes No Not Applicable

SIGNATURE OF MEDICAL PRACTITIONER

PRINT NAME

DATE

If interpreter present

SIGNATURE OF INTERPRETER

PRINT NAME

DATE

PART B - PATIENT CONSENT

To be completed by the PATIENT / Person Responsible

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand clinical images may be taken as part of my clinical management and may form part of the Medical Record. I understand these images will not be used for any other purposes without my consent.

I request and consent to the procedure/treatment, described above:

PATIENT / RESPONSIBLE PERSON(S) SIGNATURE

DATE

PRINT NAME OF PATIENT / PERSON RESPONSIBLE

IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)



RHC101740

BINDING MARGIN - DO NOT WRITE

SURGICAL CONSENT FOR TREATMENT (PRIVATE)

RHC200