Minchinbury
Community Hospital

CONSENT FORM

Consent for surgical and /or medical treatment.

MEDICAL RECORD No.:	
SURNAME:	
GIVEN NAMES:	
DOB:	SEX: M F
AFFIX PATIENT LABEL HERE IF AVAILABLE	

PART A: Provision Of Information To Patient (To be completed by medical practitioner)

I, Doctor _____ have informed _____ of the nature,

likely results and material risks of the recommended operation / procedure and /or treatment. The agreed treatment of operation / procedure is:

_____

Insert name of operation / procedure

_____

☐ Left side ☐ Right side ☐ Both ☐ N/A

Signature of Medical Practitioner _____ Date _____

Interpreter present: I, _____ have accurately interpreted the advice given by the

medical practitioner named above to _____ Date _____

Patient name *Interpreter signature*

PART B: Patient Consent (To be completed by patient)

The treating doctor whose name appears in Part A above and I have discussed my / my child's / my charges, present condition and the various way in which it might be treated. The doctor has told me that:

> The procedure / treatment carries some risks and complications may occur.

> Administration of anaesthetics, medicine or a blood transfusion may be needed and these carry some risks.

> Additional procedures or treatment may be needed if the doctor finds something unexpected.

> The procedure / treatment may not give the expected results even though the procedure / treatment will be performed with due professional care.

I understand the explanation the doctor gave me as to the needs, benefits, risks and complications related to the operation / procedure / treatment. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. I understand that I may withdraw my consent at any time prior to the commencement of the operation / procedure / treatment.

☐ Yes ☐ No I request, understand and consent to the procedure / treatment as outlined in Part A. I agree to additional anaesthetics, medicines, or procedures / treatments being carried out if required, provided that they are related to the procedure / treatment outlined in Part A.

☐ Yes ☐ No I consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV, should contamination of any staff member or myself occur during my hospital stay.

☐ Yes ☐ No I consent to a blood transfusion if needed.

_____ Date _____

Patient/parent/guardian signature

_____

Print name of patient/parent/guardian

CONSENT FORM

MR 0001A/2

BINDING MARGIN — DO NOT WRITE