Healthscope

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Mobile Number: .....

Dr: .....

INSURANCE TYPE

☐ Private ☐ DVA ☐ ADF ☐ Workcover ☐ Third Party / Motor Vehicle (TAC) ☐ Self-Funded ☐ Other: _____

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, likely results, and material risks of the recommended operation / procedure and/or treatment. I have also discussed the alternative treatments / procedures which are available.

The agreed operation / procedure / treatment is:

_____

_____

_____

(Insert name of operation / procedure / treatment)

MBS Item Number(s):

☐ Left Side
☐ Right Side
☐ Not applicable

Will this procedure have a cosmetic portion? ☑ Yes ☐ No

Estimated Theatre Time: _____Hrs_____Mins

_____

Medical Practitioner Signature

Date / /

Admission Date / / **Time** _____

Operation Date / /

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

I, _____

(Name of interpreter)

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

which is: _____

_____

Interpreter's Signature

Date / /

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 charge's present condition and the various ways in which it might be treated. The doctor has told me that:

- The operation / procedure / treatment carries some risks and complications may occur.
- Anaesthetics, medicines, and/or 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.
- Which alternative treatments / procedures are available.

I understand the nature of the procedure / treatment and that undergoing the procedure / treatment carries risks. 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 procedure / treatment.

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 they are related to the procedure / treatment outlined in Part A. I also consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV and Hepatitis B and C, should contamination of any staff member or myself occur during my hospital stay.

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

_____

Signature of Patient / Parent / Guardian

/ /

Date

_____

Print name of Patient / Parent / Guardian

_____

Signature of Witness of Signatory (adult person)

/ /

Date

_____

Print name of Witness of Signatory

HS000024

Print Media Group HSHGXFMR047A 06/21

Healthscope

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Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Mobile Number: .....

Dr: .....

CERTIFICATION OF INABILITY TO GIVE CONSENT FOR EMERGENCY PROCEDURES (To be completed by Medical Practitioner)

The undersigned registered medical practitioner certifies that _____
(Name of patient)

is incapable of giving effective consent by reason of _____
(State reason for inability to give consent, for example unconscious)

their Next of Kin is unable to give consent due to _____
(State reason for inability to give consent, for example uncontactable)

for the procedure(s) stated: _____

and that immediate treatment is necessary in order to avert a serious and imminent threat to the patient's life or physical or mental health.
I / We have no knowledge of any prior written refusal to consent to the procedure(s) having been communicated to any medical practitioner.

(Signature)	*(Print Surname)*	*Date*
		/ /
		/ /

Second signature may not be available in extreme circumstances ie. second Medical Practitioner is not available

ADMISSION DETAILS (To be completed by Medical Practitioner)

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

ICU required Post-Op? * ☐ Yes ☐ No

Pre Admission Clinic? * ☐ Yes ☐ No

* If the service is provided by the hospital

Referrals Required: _____

Special Instructions / Past History _____

_____ / /

Medical Practitioner's Signature *Date*

BINDING MARGIN – DO NOT WRITE IN THIS AREA

HS000024