Healthe Care

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

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

OR USE LABEL

DOCTOR TO COMPLETE WITH PATIENT

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)

Provisional Diagnosis

The agreed operation / procedure / treatment is:

(insert procedure / treatment — DO NOT use abbreviations)

MBS Item Number(s):

☐ Left Side ☐ Right Side ☐ Bilateral ☐ 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 or administration of blood products if needed?** ☐ **Yes** ☐ **No**

Signature of Patient / Parent / Guardian

Date / /

Print name of Patient / Parent / Guardian

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT MR/53N

HC053N

Print Media Group – HECZGFMR053N 08/22

Healthe Care

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

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Master ☐ Mx ☐ Other ______________

______________________ ______________________________

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 [ ]

VTE Prophylaxis	☐ Risk Assessed	Risk Factors Identified	☐ Yes ☐ No
	☐ Not Required	☐ Required	☐ Contraindicated

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: ______________