Please use I.D. label or block print

GRH
Hospital / Health Service

Patient Consent to Treatment or Investigation - Adult or Mature Minor

WARD: Day surgery
DOCTOR: Mr. G. Menezes

SURNAME	UMRN / MRN	
GIVE [redacted] Male	DOB	GENDER
ADDI [redacted]		POSTCODE
	TELEPHONE	

XC300520

Treatment / Procedure / Investigation - noting correct side/correct site

[redacted]

This procedure requires: ☒ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation
An Anaesthetist will explain the risk of general or regional anaesthesia to you.

Signature of doctor / health professional who has determined the consent process has occurred

Risks and benefits have been discussed with the patient and relevant consent discussions are to be documented in the medical record. Specific risks particular to this patient are: bleeding, infection, perforation, ileus, collection

Full name J Dabbour **Position/Title** Gen-surg. reg
Signature _____ **Date** 16/12/19

Patient's declaration

- I have been given written information about the procedure/treatment.
- I understand that the doctor/health professional may not perform the procedure him/herself.
- I have been informed of the risks that are specific to me, benefits, alternatives (including if I choose not to have the procedure/treatment) and the likely outcomes.
- I have been given the opportunity to ask questions about this procedure and my specific queries and concerns have been answered.
- I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
- I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
- If a staff member is exposed to my blood, **I consent** to my blood being collected and tested for infectious diseases. I will be informed if this occurs and will be given results of the tests.
- I consent to a blood transfusion, if needed ☒ Yes ☐ No (please tick). The risks have been explained to me. Note: If a blood transfusion is anticipated, please complete the Consent to Blood Products Form MR30G.
- I consent to undergo the procedure/s or treatment/s as documented on this form.

Patient's Full name [redacted] [redacted]
Patient's signature _____ **Date/Time** 16/12/19

Interpreter's declaration

Specific language requirements (if any) _____
I declare that I have interpreted the dialogue between the patient and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

Interpreter's Full name _____ **Date/Time** _____
Agency name _____ **Interpreter's signature** _____

Review of consent (if applicable)

I confirm that the patient's consent, personal circumstances and clinical condition has been reviewed and the treatment/procedure is still to be undertaken.

Full name (doctor/health professional) _____ **Position/Title** _____
Signature _____ **Date** _____
I confirm that the request and consent for the operation/procedure/treatment above remains current.
Signature _____ **Date** _____
(consenting person)

HCWZZPAD030A

WMR30A
07/17

MR 30A Patient Consent to Treatment or Investigation -

XC300520

Please use I.D. label or block print

Hospital / Health Service

Patient Consent to Treatment or Investigation - Adult or Mature Minor

WARD: _____

DOCTOR: _____

SURNAME [redacted]

GIVEN NAMES

ADDRESS

GENDER

POSTCODE

TELEPHONE

Treatment / Procedure / Investigation - noting correct side/correct site

[redacted]

An Anaesthetist will explain the risk of general or regional anaesthesia to you. ☐ Local Anaesthesia ☐ Sedation

Signature of doctor / health professional who has determined the consent process has occurred

Risks and benefits have been discussed with the patient and relevant consent discussions are to be documented in the medical record. Specific risks particular to this patient are: pain, bleed, mft, scar stoma, anastomotic leak/fist, collection, re-operation

Full name _____ **Position/Title** _____

Signature _____ **Date** 11/9/19

Patient's declaration

- I have been given written information about the procedure/treatment.
- I understand that the doctor/health professional may not perform the procedure him/herself.
- I have been informed of the risks that are specific to me, benefits, alternatives (including if I choose not to have the procedure/treatment) and the likely outcomes.
- I have been given the opportunity to ask questions about this procedure and my specific queries and concerns have been answered.
- I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
- I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
- If a staff member is exposed to my blood, **I consent** to my blood being collected and tested for infectious diseases. I will be informed if this occurs and will be given results of the tests.
- I consent to a blood transfusion, if needed ☑ Yes ☐ No (please tick). The risks have been explained to me. Note: If a blood transfusion is anticipated, please complete the Consent to Blood Products Form MR30G.
- I consent to undergo [redacted] ed on this form.

Patient's Full name _____

Patient's signature _____ **Date/Time** 11-9-19

Interpreter's declaration

Specific language requirements (if any) _____

I declare that I have interpreted the dialogue between the patient and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

Interpreter's Full name _____ **Date/Time** _____

Agency name _____ **Interpreter's signature** _____

Review of consent (if applicable)

I confirm that the patient's consent, personal circumstances and clinical condition has been reviewed and the treatment/procedure is still to be undertaken.

Full name (doctor/health professional) _____ **Position/Title** _____

Signature _____ **Date** _____

I confirm that the request and consent for the operation/procedure/treatment above remains current.

Signature _____ **Date** _____

(consenting person)

HCWZZPAD030A

MR30A
07/17

MR 30A Patient Consent to Treatment or Investigation - Adult or Mature Minor