Austin Health

Austin Health
853532
BOYLE Timothy
M M DOB: 2/07/1968
~~845 Heidelberg Road~~
~~ALPHINGTON 3078~~
0401 715 032
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FAH109200

Refer Austin Health Consent Policy on Intranet

Doctor to complete form & explain matters on the reverse of this form to the patient (or agent / guardian / person responsible within the meaning of the Guardianship Act). Note: Person responsible is defined in the Guardianship and Administration Act and is explained in the consent policy.

If the patient is from a Non English Speaking Background (NESB) an interpreter is available through:
Language Services, extension or Pager No. 3367

Interpreter Required	Yes ☐	No ☐
Services Provided	Yes ☐	No ☐

Language Spoken

I (the Doctor) have informed

Name of Patient: TIMOTHY BOYLE

Or name of agent / guardian / person responsible:
(please circle)

Regarding the proposed procedure / treatment, including the nature and likely results of, and relevant risks associated with that treatment.

Name of proposed procedure / treatment(s)

Use of histology images for journal publication

Written information regarding this procedure / treatment(s) has been provided Yes ☐ No ☐

Specific Risks explained

I (the patient / agent / guardian / person responsible) have discussed the condition being treated and understand the ways in which it may be treated, to my satisfaction. I understand and agree to the matters explained by the doctor and as listed on the reverse of this form.

I (the patient / agent / guardian / person responsible) have the following specific requests regarding the proposed procedure / treatment(s)

I (the patient / agent / guardian / person responsible) agree to the procedure / treatment(s) specified above being performed, including any other specific procedure / treatment(s) which my doctor reasonably believes are necessary during the course of the procedure / treatment(s).

Signature of patient / agent / guardian / person responsible

Signature of Doctor

Print Name
Tim Boyle

Print Name
A. Testor.

If signed by the agent / guardian / person responsible, what is your relationship to the patient

Treating Unit

Please provide a photocopy if requested.

Date: 17 / 10 / 16

2199
12/2008

Request for Procedure / Treatment

M 40.0

PROPOSED PROCEDURE

I understand and agree to the following matters as explained by the doctor:

- I understand that the procedure may carry risks and may not lead to the expected outcome. The risks of the proposed procedure have been explained to me and I have had an opportunity to ask questions about them.
- I am aware that the hospital reserves the right to postpone or cancel my procedure / treatment(s) at any time should any unforeseen circumstances arise.
- I realise that the Doctor / Surgeon who saw me originally and who placed my name on the waiting list may not be the person who performs the procedure / treatments(s).
- I accept that an anaesthetic or blood transfusion(s) may be needed in the course of the named procedure / treatment(s) and these may have some risks and after having been advised of these risks, I accept the possible associated risks.
- I understand that, in conjunction with the above stated procedure / treatment(s), I may need other additional procedure / treatment(s) as may be found necessary in the reasonable opinion of the doctor to preserve my health or life.
- I understand that as this is a teaching hospital, ancillary personnel / students / other doctors may be present or involved during my procedure / treatment(s) at the discretion of the treating doctor.
- I understand that if I am concerned about changes in my condition or circumstances that occur while I am on the waiting list, I should contact the Medical / Surgical Unit at Austin Health for advice.
- I have had my questions / concerns regarding the above named procedure / treatment(s) answered to my satisfaction.
- I understand that I can withdraw my consent at any time prior to the procedure / treatment.

Initial from Doctor .....

Initial Patient / Agent / Guardian / Person Responsible .....

I understand that if I have any concerns or questions regarding my procedure / treatment(s) I will contact the Medical / Surgical unit.

Surgical / Medical Unit: ..... Contact Number: .....