NSW Health

Facility:

FAMILY NAME

GIVEN NAME ☐ MALE ☐ FEMALE

St George Hospital [redacted]

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

(For patients 14 years and above – not for Guardianship Act purposes.)

SMR020001

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr MARK JOSEPH MACARANAS have discussed with this patient the various ways of treating
(insert name of medical practitioner)
the patient's present condition including the following proposed procedure/treatment:

[redacted]

I have informed this patient of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

[redacted] 07 / 05 /20 18 (DATE) (TIME)

Interpreter present* [redacted] / /20 (DATE) (TIME)

PATIENT CONSENT

To be completed by Patient

Dr MARK JOSEPH MACARANAS and I have discussed the present condition and the various ways
(insert name of medical practitioner)
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;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand the nature of the procedure 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.
I have been told that another doctor may perform the procedure/treatment.*
I request and consent to the procedure/treatment described above for me.

DELETE IF NOT REQUIRED

This part must be countersigned by your doctor

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to have the following aspects of the recommended procedure or treatment: (insert details)

(medical practitioner's acknowledgement)

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/~~do not consent~~*** to a blood transfusion if needed.

[redacted] 07 / 05 /20 18 (DATE)

(TIME)

A229033

* delete where not applicable

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR020.001

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

NO WRITING

NSW Health

Facility:

FAMILY NAME | MRN

[redacted]

Adm: 06-May-2018

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

AMO: Dr Selwyn Selvandran | File: MW

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

(For patients 14 years and above – not for Guardianship Act purposes.)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr SKLOMORE (insert name of medical practitioner) have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment:

[redacted]

I have informed this patient of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

[redacted] DATE 9/5/2018 TIME 2:45

Interpreter present* [redacted] DATE ___/___/20___ TIME _____

PATIENT CONSENT

To be completed by Patient

Dr SKLOMORE (insert name of medical practitioner) and I have discussed the present condition and the various 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;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure 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.
I have been told that another doctor may perform the procedure/treatment.
I request and consent to the procedure/treatment described above for me.

DELETE IF NOT REQUIRED — *This part must be countersigned by your doctor*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to have the following aspects of the recommended procedure or treatment: _____ (insert objection)

_____

_____ (medical practitioner's acknowledgement)

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I consent/do not consent* to a blood transfusion if needed.

DATE 9/5/2018

TIME 2:45 pm

_____

_____

* delete where not applicable

NO WRITING

Continue overleaf...

SMR020001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

SMR020.001

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

AMO: Dr Sellvyt Selvandran

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

(For parents/guardians of patients less than 16 years of age)

SMR020003

Provision of information to patient

To be completed by Medical Practitioner

I, Dr SJ SKIDMORE (PRINT NAME OF MEDICAL PRACTITIONER) have discussed with this patient's parent/guardian the various ways of treating the patient's present condition including the following proposed procedure/treatment:

CT abdomen / Pelvis scan with Percutaneous drainage of abscess +/- pig tail drain insertion (DO NOT USE ABBREVIATIONS)

I have informed this parent/guardian of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

[redacted] 9/5/2018 (DATE) 14:03 (TIME)

Interpreter present * (INTERPRETER'S NAME) (DATE) /20 (TIME)

Patient consent

To be completed by Parent/Guardian

Dr SJ SKIDMORE (PRINT NAME OF MEDICAL PRACTITIONER) and I have discussed the present condition of .

and the various 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;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure 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.

*I have been told that another doctor may perform the procedure/treatment.

I request and consent to the procedure/treatment described above for (PRINT NAME OF CHILD)

DELETE IF NOT REQUIRED **This part must be countersigned by your doctor if retained**

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent for my child to have the following aspects of the recommended procedure or treatment.

(DESCRIPTION OF OBJECTION)

(PARENT/GUARDIAN'S SIGNATURE)

I note that the Children and Young Person's (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I consent/do not consent* to a blood transfusion if needed.

9/5/2018 (DATE) (PRINT NAME OF PARENT/GUARDIAN)

(ADDRESS)

*Delete where not applicable

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT (For parents/guardians of patients less than 16 years of age) SMR020.003