Ramsay
Health Care

CONSENT FOR TREATMENT (PRIVATE)

PART A - PROVISION OF INFORMATION TO THE PATIENT
To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED OR EMPLOYED PRACTITIONER

I have informed ..... and/or
PRINT NAME OF PATIENT

..... / .....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) RELATIONSHIP (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment: .....

.....

.....

.....

.....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

- Side of procedure/treatment: ☐ Left ☐ Right ☐ Not Applicable
- I have explained to the patient that blood products/blood transfusions may be needed during or following the procedure. The potential risk and complications related to this have also been explained.
  ☐ Yes ☐ No ☐ Not Applicable
- The patient has consented to blood products/blood transfusions, if needed.
  ☐ Yes ☐ No ☐ Not Applicable

.... 6/9/21
SIGNATURE OF MEDICAL PRACTITIONER PRINT NAME DATE

If interpreter present

.....
SIGNATURE OF INTERPRETER PRINT NAME DATE

PART B - PATIENT CONSENT
To be completed by the PATIENT / Person Responsible

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand clinical images may be taken as part of my clinical management and may form part of the Medical Record. I understand these images will not be used for any other purposes without my consent.

I request and consent to the procedure/treatment, described above:

.....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE DATE

.....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

DO NOT WRITE IN THIS BINDING MARGIN

CONSENT FOR TREATMENT (PRIVATE)

RHG200