NSW GOVERNMENT Health

Facility:

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.C

AD

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 ..... 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:

.....

.....

.....

.....

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

..... SIGNATURE OF MEDICAL PRACTITIONER | 4 / 10 /20 18 DATE | ..... TIME

Interpreter present* ..... SIGNATURE OF INTERPRETER | ..... / ..... /20 ..... DATE | ..... TIME

PATIENT CONSENT

To be completed by Patient

Dr ..... 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 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.

..... SIGNATURE OF PATIENT | 4 / 10 /20 18 DATE

..... PRINT NAME OF PATIENT | ..... TIME

ADDRESS .....

.....

*delete where not applicable

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

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