

URN: B8218508, Printed By: Siddens, Edward (HDWA\he113478), 20 Apr 2020 15:23:27

FIONA STANLEY HOSPITAL

**PATIENT CONSENT TO
TREATMENT OR INVESTIGATION**

WARD

DOCTOR

M Khanbani

SURNAME

GIVEN NAMES

ADDRESS

UNIT

GENDER

POSTCODE

PHONE

This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

- ☐ The patient has been informed of the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications.
- ☐ The treatment/procedures/investigations noted below on this form have been explained to the patient.
- ☒ The treatment/procedures/investigations, identified below, and what is entailed for the patient has been explained to the patient.
- ☒ The patient has been provided with information specific to the procedure identified. The patient has been asked to read information provided and ask the doctor/proceduralist questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient's medical record (if applicable).

Information provided to the patient includes:

☒ **Open access procedures**

Opportunity to discuss the proposed procedure, benefits and risks, both general and specific and the risk of not having the procedure was given to the patient.

☐ **Other procedures**

The proposed procedure, benefits and risks, both general and specific, and the risks of not having the procedure have been explained.

Name of person explaining procedure:

M Khanbani

Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

Whipple's pancreaticoduodenectomy.

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

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:
Bleeding, Infection, Clots, Pancreatic leak, Bile leak,
Duodenal fistula, Post-OP DM etc. Mortality

Signature of doctor/proceduralist obtaining consent

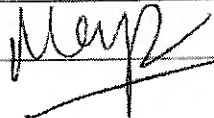
Full name (please print)

M Khanbani

Position/Title

Consultant

Signature



Date

2/3/18

DO NOT WRITE IN MARGIN

HCHFSFMR440

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF THE HISTORY OF ARTS
AND ARCHITECTURE

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FIONA STANLEY HOSPITAL

**PATIENT CONSENT TO
TREATMENT OR INVESTIGATION**

WARD _____

DOCTOR M Bhattacharya

SURNAME

GIVEN

ADDRESS

DATE

DOB

GENDER

POSTCODE

TELEPHONE

Patient's declaration

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure **prior to signing the consent form**.

- ☒ The doctor/proceduralist has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to me and associated risks, including the risks of **not** having the procedure.
- ☒ The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
- ☒ I **understand** that the result/outcome of the treatment/procedure cannot be guaranteed.
- ☒ I **understand** that if I am treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing training.
- ☒ I **understand** that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.
- ☒ If a staff member is exposed to my blood, I **consent** to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.
- ☒ I **agree** for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.
- ☒ 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.
- ☒ I **consent** to undergo the procedure/s or treatment/s as documented on this form.
- ☐ I **consent** to a blood transfusion, if needed ☒ Yes ☐ No (please tick appropriate box)

Patient's full name _____

Patient's signature _____

Date/Time 2/3/18

Parent/guardian signature _____

Date/Time _____

(if desired for mature minor)

Declaration by InterpreterInterpreter Service Used: ☐ Yes ☐ No If Yes, specify: ☐ Telephone ☐ On Site

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

Name (please print) _____ Signature _____

Date _____ NAATI number _____ Language _____

Confirmation of consent at pre-admission or admission to hospital

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

Patient's signature _____ Date/Time _____

(patient/person responsible)

DO NOT WRITE IN MARGIN

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FIONA STANLEY FREMANTLE HOSPITAL GROUP

**PATIENT CONSENT TO
TREATMENT OR INVESTIGATION**

WARD

DOCTOR

MB Hendari

GIVEN NAME

ADDRESS

Date:

GENDER

POSTCODE

TELEPHONE

Treatment / Procedure / Investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site (No abbreviations)

*Edworthy (apathy)***Disclosure of material risks**

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:

☐ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation

An Anaesthetist will explain the risk of general or regional anaesthesia to you.

Patient's declaration

- I consent to undergo the procedure/s or treatment/s as documented on this form.
- 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 there are unexpected findings or if an event occurs 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.
- 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.

- I understand that the doctor/health professional may not perform the procedure him/herself.

Signature of patient

Date

B/S/L

Print Name

Signature of person consenting
(if not the patient)

Date

Print Name

Relationship to patient

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

Risks, benefits and expected outcomes have been explained to the patient by Dr _____
Relevant consent discussions have been documented in the medical record.

Full name

Position/Title

Signature

Date

*13/3/18***Interpreter's declaration (if applicable)**

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.

Language spoken

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 have been reviewed and the treatment/procedure is still to be undertaken.

Full name (doctor/health professional)

Position/Title

Signature

Date

MR 440 PATIENT CONSENT TO TREATMENT OR INVESTIGATION



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