



Health

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

Facility:

SWH

# REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

LOCATION

Fin: MW

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 Rene / Bunak / Kratoch have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment:

hysteroscopy + splenectomy + colectomy and proctectomy

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

DATE

TIME

Interpreter present\*

SIGNATURE OF INTERPRETER

DATE

TIME

## PATIENT CONSENT

To be completed by Patient

Dr Kratoch 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.

Risk: Bleeding  
stomach  
infection

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.

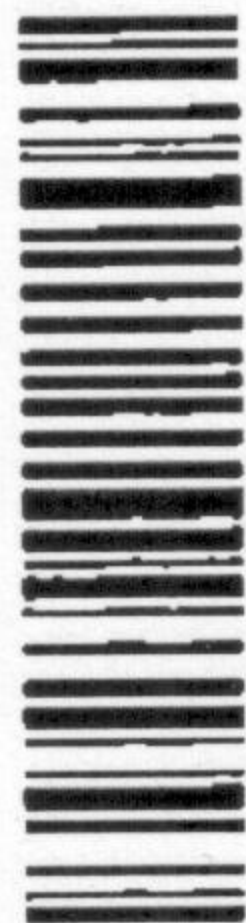
NATURE OF PATIENT

DATE

PRINT NAME OF PATIENT

TIME

ADDRESS



SMR020001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REQUEST / CONSENT FOR  
MEDICAL PROCEDURE TREATMENT

SMR020.00

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