StVincent's LISMORE

CONSENT FOR MEDICAL PROCEDURE/TREATMENT

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

❑ Day Only
❑ In-Patient

❑ Private
❑ Workers Comp
❑ DOH

❑ Uninsured
❑ MVA
❑ DVA

Adult and Mature Minors with capacity

If in doubt about the capacity of a minor, refer to section 4.5.3 of SVL policy (2015_009) Consent to Medical Treatment

PROVISION OF INFORMATION TO PATIENT — **To be completed by Medical Practitioner**

I, Dr ..... have discussed with this patient the various ways
INSERT NAME OF MEDICAL PRACTITIONER

of treating the patient's present condition including the following proposed procedure/treatment:

.....
(insert site name and reasons for procedure or treatment; do not use abbreviations)

.....

Planned CMBS Item Number(s) .....

I have informed this patient of the nature, likely results and material risks of the proposed procedure/treatment and of the matters in the section below.

I have assessed this patient to be a minor with capacity to give consent ('a mature minor') as they have demonstrated sufficient maturity and intellect to fully understand what is proposed. ❑ Yes ❑ No ❑ N/A

	SIGNATURE OF MEDICAL PRACTITIONER	...../...../20..... DATE	..... TIME
Interpreter present*	SIGNATURE OF INTERPRETER	...../...../20..... DATE	..... TIME

PATIENT CONSENT — **To be completed by Patient**

Dr ..... and I have discussed my present condition and the various
INSERT NAME OF MEDICAL PRACTITIONER

ways in which it might be treated, including the above procedure/ 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/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/treatment and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and am satisfied with the explanation and answers to my questions.

I understand that I may withdraw my consent.

❑ I **consent** to the procedure/treatment described above and I also **consent** to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment for me.

DELETE IF NOT REQUIRED *(This section must be countersigned by your doctor as acknowledgement of refusal)*

While I consent to the proposed procedure/treatment, after discussing this matter with the doctor, I **refuse consent** to have the following aspects of the recommended procedure/treatment:.....
insert objection

.....

..... *Medical Practitioner's Signature* .....

❑ **I consent to a blood transfusion if required.**

❑ **I DO NOT consent to the transfusion of blood or ANY blood products.**

SIGNATURE OF PATIENT	PRINT NAME OF PATIENT	...../...../20..... DATE	..... TIME

BINDING MARGIN – DO NOT WRITE

SVH037 Rev May 25

CONSENT FOR MEDICAL PROCEDURE / TREATMENT - ADULT / MATURE MINORS