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

MINORS

(For PARENTS/GUARDIANS of minors without capacity)

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

I, Dr ..... have discussed with this patient's parent/guardian* the various
INSERT NAME OF MEDICAL PRACTITIONER

ways 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 **parent/guardian*** of the nature, likely results and material risks of the proposed procedure/ treatment and of the matters in the section below.

..../...../20..... .....
SIGNATURE OF MEDICAL PRACTITIONER DATE TIME

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

PATIENT CONSENT — **To be completed by Parent/Guardian**

Dr ..... and I have discussed the present condition of .....
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF MINOR

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/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 .....
INSERT NAME OF MINOR

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

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

.....

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

I note that the Children and Young Persons (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

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

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

..../...../20..... .....
SIGNATURE OF PARENT/GUARDIAN DATE TIME

....
PRINT NAME OF PARENT/GUARDIAN RELATIONSHIP TO CHILD OF PARENT/GUARDIAN

* Delete where not applicable

BINDING MARGIN – DO NOT WRITE

SVH038 Rev May 25

CONSENT FOR MEDICAL PROCEDURE / TREATMENT - MINORS