StVincent's LISMORE

REQUEST/CONSENT FOR MEDICAL PROCEDURE/TREATMENT

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

❑ Day Only

❑ In-Patient

❑ DOH
❑ DVA
❑ Workers Comp
❑ Private
❑ Uninsured

ADULT

(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
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 matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

.....	...../...../20.....	.....	
SIGNATURE OF MEDICAL PRACTITIONER	DATE	TIME	
Interpreter present*	...../...../20.....	.....	
SIGNATURE OF INTERPRETER	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 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 also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **request and consent** to the procedure/treatment described above for me.

I **also consent to a transfusion of blood and/or blood products** if needed.

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

OR

I **request and consent** to the procedure/treatment described above for me.

I **do not consent to a transfusion of blood and/or blood products** if needed.

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

BINDING MARGIN – DO NOT WRITE

REQUEST / CONSENT FORM

DELETE IF NOT REQUIRED *(This part must be countersigned by your doctor if retained)*

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

.....

insert objection

..... *Medical Practitioner's Acknowledgment* .....

USE OF REMOVED TISSUE

I understand that the proposed procedure may involve the removal of some bodily tissue, which may be required for the diagnosis or management of my condition.

I **consent/do not consent*** to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

.....

(insert terms if any)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

..../...../20.....

SIGNATURE OF PATIENT | PRINT NAME OF PATIENT | DATE

BINDING MARGIN – DO NOT WRITE

*Delete where not applicable