StVincent's
LISMORE

SUBSTITUTE REQUEST/CONSENT FOR MEDICAL PROCEDURE/TREATMENT

❑ Day Only

❑ In-Patient

❑ DOH
❑ DVA
❑ Workers Comp
❑ Private
❑ Uninsured

UR:
Family Name:
Given Names:
Date of Birth: Gender: M ❑ F ❑

GUARDIANSHIP ACT 1987

(For patients 16 years and above where consent is provided by a person responsible)

MEDICAL ADVICE **To be completed by Medical Practitioner**

I, Dr .... confirm that .... is
INSERT NAME OF MEDICAL PRACTITIONER NAME OF PATIENT

incapable of consenting to medical treatment because:

(Tick one) or
☐ he/she cannot understand the nature and effect of the treatment
☐ he/she cannot indicate whether or not he/she consents

The patient's condition that requires treatment is ....

Significant risks in not treating are ....

....

The site of the proposed procedure or treatment and its general nature and effect are ....

....
INSERT SITE NAME AND REASONS FOR PROCEDURE OR TREATMENT; DO NOT USE ABBREVIATIONS
....

....

Planned CMBS Item Number(s) ....

The proposed procedure/treatment has the following significant risks and/or side effects ....

....

....

Reasonable alternatives (if any) to the proposed procedure/treatment and significant risks and/or side effects associated are ....

....

....

The proposed treatment is the most appropriate form of treatment to promote the patient's health and well-being.

.... and I have discussed the patient's present condition and I have
NAME OF PERSON RESPONSIBLE

also explained:

- that other forms of treatment, such as anaesthetics, medicines or blood transfusions may be associated with the procedure/treatment and that those may carry some risks;
- that other unexpected procedures or treatment are sometimes necessary;
- that complications may occur or the expected result may not be achieved even though the procedure/treatment is carried out with due professional care.

..../........./20......... ..../........./20.........
SIGNATURE OF PERSON RESPONSIBLE DATE SIGNATURE OF MEDICAL PRACTITIONER DATE

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

BINDING MARGIN – DO NOT WRITE

REQUEST / CONSENT FORM – SUBSTITUTE CONSENT

ACKNOWLEDGEMENT ADVICE — To be completed by the person responsible/guardian

Dr.. and I have discussed ....'s
INSERT NAME OF MEDICAL PRACTITIONER — INSERT NAME OF PATIENT

present condition and the various ways in which it might be treated above. The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- the patient may need an anaesthetic, medicines, or blood transfusion, 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.

..../........../20..........
SIGATURE OF PERSON RESPONSIBLE — PRINT NAME OF PERSON RESPONSIBLE — DATE

SUBSTITUTE CONSENT — To be completed by the person responsible/guardian

I **request and consent** to the procedure/treatment described above for ....
INSERT NAME OF PATIENT

I have considered the views of the patient and consider the treatment should be provided to the patient. I am satisfies the treatment will promote the health and wellbeing of the patient.

I accept the risks involved in the procedure/treatment.

I consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

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

..../........../20..........
SIGATURE OF PERSON RESPONSIBLE — PRINT NAME OF PERSON RESPONSIBLE — DATE

....
RELATIONSHIP TO PATIENT IN TERMS OF THE ACT

OR

I **request and consent** to the procedure/treatment described above for ....
INSERT NAME OF PATIENT

I have considered the views of the patient and consider the treatment should be provided to the patient. I am satisfies the treatment will promote the health and wellbeing of the patient.

I accept the risks involved in the procedure/treatment.

I consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

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

..../........../20..........
SIGATURE OF PERSON RESPONSIBLE — PRINT NAME OF PERSON RESPONSIBLE — DATE

....
RELATIONSHIP TO PATIENT IN TERMS OF THE ACT

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

Except that after discussing this mater with the doctor, I do not consent to the following aspects of the recommended procedure/treatment:

....
insert objection

Medical Practitioner's Acknowledgment

USE OF REMOVED TISSUE

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis or management of ....'s condition.
INSERT NAME OF PATIENT

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 ....'s condition.
INSERT NAME OF PATIENT

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

*Delete where not applicable

BINDING MARGIN – DO NOT WRITE