



HOSPITAL ADMINISTRATION SECTION ONLY
AFFIX PATIENT LABEL HERE:

Consent to Procedure

Doctor's Details

I, Dr (insert name)

have discussed with the patient/parent/guardian the patient's present condition, alternative treatments available and explained the benefits and risks of the proposed operation/procedure which is (insert procedure):

MEDICAL OFFICER'S SIGNATURE:

Patient Details

I (insert name),

request the above operation/procedure be performed on me.

OR

I (insert name),

as Parent / Guardian / EPOA (tick appropriate response) *Please bring the original form at time of admission.*

of (insert patient's name)

request the above operation/procedure be performed on them.

I also request the administration of anaesthetics, medicines or other forms of treatment normally associated with this procedure.

I understand that other associated procedures may be necessary and I request that these be carried out if required.

I understand and consent to a sample of blood being tested if there is an injury to either my doctor or a hospital staff member during the proposed procedure.

Although this procedure will be carried out with all due professional care/responsibility, I understand that in some circumstances the expected result may not be achieved.

I understand that complications may occur with any procedure and I accept the possible risks associated with this procedure and will be responsible for costs incurred.

I have had the opportunity to ask questions about the procedure and I am satisfied with the information I have received.

Following surgery I will have a responsible adult accompany me home by motor vehicle and stay with me for a minimum of 24 hours following surgery and I have made arrangements for this. I realise that impairment of full mental alertness may persist for several hours following the administration of anaesthesia and I will avoid making any decisions or taking part in activities which depend on full concentration, co-ordination or judgment for a minimum of 24 hours.

In the event a blood transfusion is clinically indicated, I consent to blood transfusion

Yes

No

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:

Date:

Specify relationship to patient Mother / Father / EPOA / Other (please state):

A copy of the Enduring Power Of Attorney (EPOA) must accompany this consent form if there is one in place