CONSENT TO OPERATION / PROCEDURE / TREATMENT

UR No:.....

SURNAME:.....

GIVEN NAMES:.....

DATE OF BIRTH:.....

SEX:.....

ATTACH LABEL IF AVAILABLE

CONSENT TO OPERATION / PROCEDURE / TREATMENT

I, ……...
(Given Names) (Surname)

consent to the following operation(s)/procedure(s)/treatment(s) *(specify side if applicable)*:

……..

……..

being performed upon ……..
(Given Names) (Surname)

The nature and effect of the above operation(s)/procedure(s)/treatment(s) have been explained to me by

……..… ……
(Print: Medical Practitioner or Authorised Delegate) (Signature: Medical Practitioner or Authorised Delegate)

Interpreter translating: ……
(Name of Interpreter)

Please read the following information before you sign this form

1. I consent to clinical photographs which may be taken as a record of the operation(s)/procedure(s)/ treatment(s).

2. I also consent to such further or alternative procedures/measures/treatments as may be found necessary to be performed during the course of the operation(s)/procedure(s)/treatment(s).

3. I have been informed of the possible significant risks and complications, benefits, alternatives and goals of the recommended operation/procedure/treatment specific to my individual circumstances, and that I have considered them in deciding to undergo this procedure.
Specific written information has been provided (please tick): ☐ Yes ☐ No

   If yes, Medical Practitioner or Authorised Delegate to specify document provided: ……

   ……

   ……

4 I acknowledge that as a Public Hospital, Medical Health Professionals may participate in my operation(s)/ procedure(s)/treatments(s) and I consent to their being present.

5. I do not consent to ……...

6. If you require a blood transfusion during this operation/procedure/treatment -
(please initial relevant statement)

☐ **I give permission** for the administration of a blood transfusion and/or other blood products as may be considered necessary by any doctor treating me.

OR

☐ **I do not give permission** for the administration of blood or blood products except as specified on the Refusal to permit Blood Transfusion form (form to be completed by doctor)

Dated this …… day of ……..2……..

Signed …….. relationship to patient …… ……..
(relationship to patient: eg my sister, my child, myself etc)

Do not write in the binding margin

07/2022

CONSENT TO OPERATION/PROCEDURE/TREATMENT MR 12/1