(NAME OF HOSPITAL)

REQUEST/CONSENT FOR
MEDICAL PROCEDURE TREATMENT

(For patients 14 years and above - not for Guardianship Act purposes)

TITLE	FAMILY NAME		MRN		
GIVEN NAMES			VMO		
ADDRESS	STREET		DOB	SEX	HIS
SUBURB		POSTCODE	ADMISSION DATE		

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

I, Dr .... (INSERT NAME OF MEDICAL PRACTITIONER) have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment (INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS)

....

....

....

....

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.

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

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

PATIENT CONSENT — **o be completed by Patient**

Dr ....(INSERT NAME OF MEDICAL PRACTITIONER).and I have discussed my present condition 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 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 have been told that another doctor may perform the procedure/treatment.*

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

REQUEST/CONSENT FORM

DELETE IF NOT REQUIRED *(This part must be countersigned by your doctor if retained)*
While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects following aspects of the recommended procedure or treatment. ....

....

insert Objection .... *Practitioner's Acknowledgement* ....

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

I **consent/do not consent*** to a blood transfusion if needed.

....…./…../20…. ....
SIGNATURE OF PATIENT DATE TIME

....
print name of patient

ADDRESS ....

....

USE OF REMOVED TISSUE (SEE SECTION 33 of CIRCULAR)

I understand that the above 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 Date

* Delete where not applicable