



CONSENT FOR TREATMENT

Surname: _____

First Name: _____

U.R. Name: _____

Ward: _____ Bed: _____

Please affix patient's identification label

PART A - To be completed by the Ramsay Treating Health Care Accredited Practitioner

I have informed _____ and/or _____ / _____
Name of patient (print) Guardian/person responsible Relationship

Of his/her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risk of the following recommended operation/procedure(s)

Procedure/Reason for Admission: *(print)* _____

• Procedure Site: _____

• Procedure side of body: Right ☐ Left ☐ Not applicable ☐

☐ Patient does not consent to having a blood / blood product transfusion

☐ Interpreter used: Name or RHC accredited interpreter _____ Language _____

Sight Translated ☐ Verbally Translated ☐

Treating Accredited Practitioner / Doctor

PART B - To be completed by the Patient / Person responsible

I _____ acknowledge that:
Print name of patient and sign below

- I have consented to the Operation / Procedure as described above or on attached consent form (please circle) _____ (name of procedure or operation)
- PDPC employees / contractors will administer care / treatment under the treating practitioner's direction or in an emergency, medical and nursing care will also be delivered as required.
- I understand the explanation the practitioner gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) and / or treatment as discussed by my practitioner above in person ☐ via telephone ☐
Date: _____ Time: _____ (please tick)
- The administration of an anaesthetic, medicines, and / or blood / blood products may be needed if in association with this operation / procedure(s) and / or treatment as discussed by my practitioner above.
- I have had the opportunity to ask questions and these have been answered in a way I understand by the practitioner above.
- I have read / seen / heard and understand the following where applicable which explains the operation / procedure(s) and the risks involved:
☐ Information Sheet(s) or Multimedia presentation on my Operation / Procedure _____
Name of Information Sheet(s)
☐ If consenting to Blood / Blood products I have received the information brochure "Blood, Who Needs It" which explains the risks involved in blood / blood product transfusion.
- I note that I am able to withdraw this consent in writing at any time prior to the commencement of treatment / procedures.

Patient / Responsible person(s) Signature

Patient / Responsible person(s) Signature

Relationship (if applicable)

Date

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Jewellery/money:

I acknowledge that Pindara Day Procedure Centre recommends that valuables are **NOT** brought to the Day Surgery. I understand that any valuables retained by myself whilst in the Day Surgery will remain my responsibility. Please initial

I have received information on my Rights and Responsibilities, and how to register a Compliment or Complaint regarding my visit to the Day Surgery.

Patient's Name: (print) Signature:.....

ADDITIONAL INFORMATION: Is there any additional information you would like the Medical/Nursing Staff to know?

.....
.....

ENDURING POWER OF ATTORNEY:

Do you have a current Advance Health Directive? **YES** ☐ **NO** ☐

Do you have Enduring Power Of Attorney - health and medical guardian? **YES** ☐ **NO** ☐

Name:..... Relationship: Phone:.....

DISCHARGE PLAN: As a Day Patient you must have someone escort you home and stay with you at least overnight but preferably for the next 24 hours after your procedure.

Who will escort you home? Name: Phone No:

Who will stay with you overnight? Phone No:

Relationship:

Does your carer require help to care for you? **YES** ☐ **NO** ☐

Do you have any concerns about your recuperation after your procedure/surgery?

YES ☐ **NO** ☐ If yes, please state

Signature:

Nurse Use Only: (Admitting nurse to check and correct as required.)

Comments / Actions / Outcomes

Signature

Designation

Print

Initials

Date & Time (Hrs)