

<b>Patient Consent to Treatment or Investigation</b>			
	Surname		UMRN
	Given names	DOB	Sex
	Address		
	Suburb		Postcode

**Patient's declaration**

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure **prior to signing the consent form**.

☐ The doctor/proceduralist has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to me and associated risks, including the risks of **not** having the procedure.

☐ The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.

☐ I **understand** that the result/outcome of the treatment/procedure cannot be guaranteed.

☐ I **understand** that if I am treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing training.

☐ I **understand** that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

☐ If a staff member is exposed to my blood, I **consent** to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

☐ I **agree** for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.

☐ I **understand** that if immediate life-threatening events happen during the procedure, I will be treated accordingly.

☐ I **understand** that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.

☐ I **consent** to undergo the procedure/s or treatment/s as documented on this form.

☐ I **consent** to a blood transfusion, if needed      ☐ Yes      ☐ No (**please tick appropriate box**)

**Patient's full name** \_\_\_\_\_

**Patient's signature** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

**Parent/guardian signature** \_\_\_\_\_ **Date/Time** \_\_\_\_\_  
 (if desired for mature minor)

**Interpreter's declaration**

Specific language requirements (if any) \_\_\_\_\_

Interpreter services required:      ☐ Yes      ☐ No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

**Interpreter's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Full name** (please print) \_\_\_\_\_

**Confirmation of consent at pre-admission or admission to hospital**

I confirm that the request and consent for the operation/procedure/treatment above remains current.

**Patient's signature** \_\_\_\_\_ **Date/Time** \_\_\_\_\_  
 (patient/person responsible)