Dalcross Wellness Hospital

CONSENT FORM

REQUEST - CONSENT FORM FOR OPERATION - PROCEDURE AND/OR MEDICAL TREATMENT

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	GENDER M F
WARD	DOCTOR
UNIT NUMBER	

Doctor's Surgical Referral Form

To be completed by Doctor and faxed to Dalcross on the day of Consultation: Please PRINT clearly.

I request patient to attend Pre-Admission Clinic ☐ Yes

Please Admit

Mr, Ms, Mrs, Miss, Master: _____ Date of Admission: ____/____/____
Surname Given Names

Address: _____

Telephone: _____ Date of Birth: ____/____/____ Sex: _____
Home Business Mobile

Clinical Details

Presenting symptoms: _____

_____

Principal diagnosis, i.e., the condition which best accounts for patient's stay in hospital: _____

_____

Other conditions present: _____

_____

Medications: _____

_____

ALLERGIES: _____

SLEEP APNOEA: Does patient suffer from this ☐ Yes ☐ No Does patient use a CPAP Machine ☐ Yes ☐ No
If Yes, patient to take CPAP Machine to hospital

DEMENTIA: Does patient suffer from this ☐ Yes ☐ No
Does patient suffer from: **Confusion** ☐ Yes ☐ No **Mental Illness** ☐ Yes ☐ No **Incontinence** ☐ Yes ☐ No

Date of operation ____/____/____ **Item Numbers** _____

Type of Anaesthetic _____ **Expected length of procedure:** _____

Expected length of stay: ☐ Day Only ☐ Overnight or longer _____ days

Specific pre-operative instructions (including tests required):

☐ Anaesthetic Consultation _____

☐ Radiology _____

☐ Pathology _____

☐ Investigations _____

☐ Drug orders on Admission _____

☐ ECG _____

☐ Special Instructions (e.g. bowel prep) _____

GP/Other Referring Doctor's Details

Name: _____ Address: _____

CONSENT FORM MR 012

BINDING MARGIN – DO NOT WRITE

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MSO123888/04/26 - Version 0

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PART A: PROVISION OF INFORMATION TO PATIENT (to be completed by Medical Practitioner)

I, Doctor _____ *(insert name of medical practitioner),*

have informed: _____ *(insert name of patient / parent / guardian),*
of the nature, likely results and material risks of the recommended operation / procedure and/or treatment.
The agreed operation / procedure and treatment that the patient is to undergo is:

Insert name of operation / procedure and/or treatment _____

_____

_____

Signature of Medical Practitioner _____ *Date* ____/____/____

Interpreter required: ☐ Yes ☐ No I, _____ , an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to _____ *(patient name)*

Signature of Interpreter _____ *Date* ____/____/____

PART B: PATIENT CONSENT (to be completed by Patient)

The doctor, whose name appears in PART A above, and I have discussed my / my child's / my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of anaesthetic, medicines and/or blood / blood products may be needed in association with this operation / procedure.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agreee to these additional operations / procedures and/or treatments being carried out if required, as long as they are related to the primary procedure set out in PART A.
- Even though the operation / procedure and/or treatment is carried out with all due professional care, the operation / procedure and/or treatment may not give the expected result.
- The operation / procedure and/or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature and risks of the procedure / operation / procedure treatment.

I have been advised of the material risks associated with this operation / procedure and/or treatment.

I have had the opportunity to ask questions about the operation / procedure and/or treatment and I am satisfied with the answers and information I have received.

I understand that I may withdraw my consent at any time prior to the operation / procedure and/or treatment.

PART C: CONSENT TO OPERATION / PROCEDURE / TREATMENT

You are required to complete SECTION 1 and have your signature witnessed by an adult who completes SECTION 2.

SECTION 1

I request, understand and consent to the operation / procedure and/or treatment as outlined in PART A.

(Signature of patient / parent / guardian / Sustitute Decision Maker): _____

(Print name of patient / parent / guardian / Sustitute Decision Maker): _____

Date: ____/____/____

SECTION 2

I, the undersigned, witnessed the signing of SECTION 1 above

(Signature of witness): _____

(Print name of witness): _____

Date: ____/____/____

NOTE: If patient is under 14 years of age, parent or guardian must sign

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