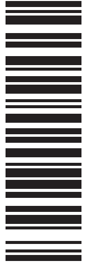
ST JOHN OF GOD
Murdoch Hospital



MU120

CONSENT TO PROCEDURE

U.R. Number ....

Surname ....

Given Names ....

Date of Birth .... Sex ....

Use Label If Available or BLOCK LETTERS

Specialist Room to Complete

PART A Provision of PATIENT INFORMATION to be completed by the SJGHC Accredited Health Professional

I have informed ______________________ (Print patient name) and/or ______________________ (Parent/Substitute Decision Maker) -/ ______________________ (Relationship)

of his/her present condition, the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications. I have recommended the treatment/procedures/ investigation noted below on this form for the diagnosis of ______________________

Treatment/procedures/investigations to be performed, noting correct side/correct site

Information provided to the patient including specific and material risks:

This procedure is likely to require: ☐ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation
Your anaesthetist will explain the risk of anaesthesia to you.

NO WRITING IN MARGINS

Doctor name (please print)______________________ **Position/Title**______________________

Signature______________________ **Date**______________________

PART B PATIENT CONSENT to be completed by the patient/person responsible

I acknowledge that I have consented to the Treatment/Procedures/Investigation as detailed above.

- The doctor/proceduralist has explained to me: my medical condition and prognosis; the relevant diagnostic treatment options available and the associated risks, including the risks of not having the procedure.
- I understand the Procedure/Treatment/Investigation carries some risk and complications may occur
- I understand that additional procedure(s) may be needed if something unexpected is found
- 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.
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure

  ☐ I **consent** to blood products, if needed

  OR

  ☐ I **do not consent** to blood products, if needed **(please complete Refusal for Blood Products form HR 123)**
- If a staff member is exposed to my blood or body fluids, 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 understand that I am able to withdraw consent 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.

Signatory's full name ______________________

Patient / Parent /Substitute Decision Maker signature ______________________

Specific language requirements: 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.

Interpreter's signature ______________ **Full name** ______________ (please print) **Date** ______________

Consent Revision

Doctor name (print) ______________ Position/Title ______________ Initial ________ Date ________

SGHMHFMR0120 05/17

CONSENT TO PROCEDURE

HR 120