



king street

PRIVATE HOSPITAL

Level 7 291 King Street, Newcastle NSW 2300 (02) 4092 8181

CONSENT TO SURGICAL OPERATION, PROCEDURE AND/OR MEDICAL TREATMENT

| | | | | | |
|--|--|---|--|---|-----------------|
| NAME: <u>Kathleen Byers</u> | | SURNAME: <u>Byers</u> | | DATE OF ADMISSION: | OPERATION DATE: |
| D.O.B.: <u>17/1/48</u> | | SEX: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | | |
| ADDRESS: | | ESTIMATED LENGTH OF STAY: | | TIME IN THEATRE: | |
| MOBILE NUMBER: | | MEDICARE & REF NUMBER: | | | |
| FUND: | | MEMBERSHIP NO. | | RELEVANT INFECTIONS: <input type="checkbox"/> MRSA <input type="checkbox"/> HEP B or C <input type="checkbox"/> VRE | |
| Affix patient label here or complete details | | | | ANAESTHETIC TYPE: <input type="checkbox"/> LA <input type="checkbox"/> GA | |

PROVISION OF INFORMATION TO PATIENT

This consent is valid for the duration of your admission

I, Medical Practitioner

have discussed with

The patient's present condition, including the nature and likely results of the operation/procedure. Although this operation/procedure is carried out with all due care and responsibility, in some circumstances the expected result may not be achieved.

PROVISIONAL DIAGNOSIS:

REQUEST THE FOLLOWING/PROCEDURE:

MBS Item Number(s):

Prostheses Required / Instrumentation / Pre-op Instructions

Known Allergies

INTERPRETER REQUIRED? ☐ YES ☐ NO

I (name of interpreter) _____ have given an accurate verbal translation of this form to consent to the treatment in the language that the patient understands.

Language: _____ Signature: _____ Date: _____

BLOOD TRANSFUSION/PRODUCTS?

I understand why I may require a blood transfusion/product and have discussed other relevant options with the doctor. I have been informed of the risk and benefits, alternatives of a blood transfusion/product. I was given a Consumer Brochure.

☐ Yes, I consent to a blood transfusion/product ☐ No, I do not consent to a blood transfusion/product

I CONSENT to the procedure/surgery as detailed in this form. In providing my consent to treatment, I acknowledge that the treatment has been explained to me by my treating medical practitioner, including the benefits, risks and alternatives, and that I have had the opportunity to ask questions. I also give consent to the taking of blood for appropriate testing of communicable diseases including Hepatitis, should contamination of any staff members, doctors, other person or myself occur during my hospital stay.

SIGNATURE OF PATIENT/GUARDIAN

DATE

I HAVE DISCUSSED WITH THE PATIENT THAT complications may occur with any operation/procedure and they accept the possible risks associated with this operation/procedure. The possible complications, risks and benefits have been explained to the patient.

SIGNATURE OF DOCTOR/SURGEON

DATE

BINDING MARGIN - DO NOT WRITE

PROCEDURE AND/OR MEDICAL TREATMENT