

<p>SPECIALIST SURGICENTRE</p> <p>CONSENT FOR TREATMENT</p>	<p>UR No.: _____</p> <p>SURNAME: _____</p> <p>GIVEN NAMES: _____</p> <p>DATE OF BIRTH: _____</p> <p style="text-align: center; color: grey; font-size: small;">PLACE PATIENT LABEL HERE</p>
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NOTES TO PATIENT
 Your doctor is required to provide you with information about the reasons for the benefits of the treatment which has been recommended for you, including discussion of the risks and complications of the treatment. It is your responsibility to discuss concerns or ask for further information from your doctor prior to consenting to your surgery.

PROVISION OF INFORMATION TO THE PATIENT

I have informed.....
(given names)
(family name)

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

Procedure/Treatment:

CONFIRMATION by Surgeon	
I, Dr/Mr/Ms <i>(name of doctor, please print)</i>	
Signature of Surgeon	Date:

CONSENT TO TREATMENT

I acknowledge that I have consented to the procedure/treatment as detailed above, or on the Doctor's own Consent form.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I have had the opportunity to ask questions about the procedure/treatment and I am satisfied with the information that I have received;
- I understand the procedure / treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to blood being taken for testing for HIV and other diseases in the event of accidental staff injury involving contact with my blood or body fluid.
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure / treatment;
- I hereby request and consent to the procedure/treatment above.

PATIENT'S SIGNATURE <i>(*if patient or parent/guardian consenting to treatment please state relationship to patient.....)</i>	
I hereby confirm that I consent to the treatment(s).	
Signature of Patient	Date:

CONSENT TO ANAESTHETIC *(**delete if not applicable)*

I have informed the patient of the anaesthetic techniques for the proposed procedure noted above, including known benefits and possible complications

- I have provided the patient with information specific to the anaesthetic techniques
- I have informed the patient of specific anaesthetic risks particular to this patient

CONFIRMATION by Anaesthetist	
I, Dr/Mr/Ms <i>(name of doctor, please print)</i>	
Signature of Anaesthetist	Date:

In conjunction with the above stated treatments/procedures, I request and consent to the administration of an anaesthetic as discussed with the anaesthetist, the risks and benefits having been discussed to my satisfaction.

with the exception of
(state name of anaesthetic, drug or procedure)

PATIENT'S SIGNATURE <i>(*if patient or guardian consenting to treatment please state relationship to patient</i>	
I hereby confirm that I consent to the anaesthetic.	
Signature of Patient	Date: