



Unit Record Number \_\_\_\_\_

Surname \* \_\_\_\_\_

Given Names \* \_\_\_\_\_

DOB \* \_\_\_\_\_ Sex \* \_\_\_\_\_

Affix patient label here or complete details

### Acknowledgement of Consent to Treatment

**Patient to complete and bring to hospital** (Parent or guardian to complete for persons under 18 years) Please tick

- \*Do you require an interpreter to assist you in completing this form  No  Yes
- \*If yes, has an interpreter been involved in completing this form  No (Please provide reason \_\_\_\_\_)  Yes
- \*Has **anyone been appointed** to make a decision about your care?<sup>1</sup>  No  Yes

If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_

- \*Have you prepared any **written requests / requirements / instructions** relating to your care?<sup>2</sup>  No  Yes

If yes, please provide a copy

### Acknowledgement of consent to treatment

I \* \_\_\_\_\_, on behalf of myself  or \_\_\_\_\_  
Print name Relationship to patient

acknowledge that **Mr Raymond Yap**  
Name of Medical Practitioner or Medical Imaging Technologist\*

has explained to me the procedure(s) or treatment(s) detailed below to my satisfaction, and I consent to these. I understand the explanation the Doctor / Medical Imaging Technologist\* gave me as to the need, benefits, risk and complications related to this procedure or treatment.

I also consent to the testing of my blood for infections, including HIV (AIDS) or Hepatitis, if a Medical Practitioner determines that any person is or may be at risk of infection through contact with me.

I further consent to the confidential use by staff at Cabrini of information contained in my Medical Record for the purposes of quality improvement.

\*for IV contrast only

**Description of procedures or treatments on** \* DD / MM / YYYY (Date of planned procedure)

\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \* \_\_\_\_\_ Date of signature: DD / MM / YYYY  
Signature of patient / relative / guardian

### Acknowledgement of consent to Anaesthesia or Sedation (To be completed after seen by Anaesthetist)

I consent to having an Anaesthetic or Sedation. I understand the explanation given to me by

Doctor: \_\_\_\_\_ as to the needs, benefits, risk and complications related to this.  
Print name of Doctor

Signature: \_\_\_\_\_ Date of signature: DD / MM / YYYY  
Signature of patient / relative / guardian

Note 1. An **agent** appointed under the Medical Treatment Act (Enduring Power of Attorney)  
A **guardian** or an **enduring guardian** appointed under the Guardianship & Administration Act.

Note 2. Refusal of Treatment Certificate under the Medical Treatment Act or an Advance Care Plan or similar document.



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ACKNOWLEDGEMENT OF CONSENT TO TREATMENT MR002D



Unit Record Number \_\_\_\_\_  
Surname \_\_\_\_\_  
Given Names \_\_\_\_\_  
DOB \_\_\_\_\_ Sex \_\_\_\_\_

Affix patient label here  
or complete details

**Please bring this form to hospital on day of admission**

**Acknowledgement of informed consent for transfusion of blood or blood products**

**Patient to complete** (Parent or guardian to complete for persons under 18 years)

Please tick

Has the Doctor discussed the possibility that you may have a transfusion of blood products?  No  Yes

- The Doctor has explained why I may need / will need a blood transfusion
- The risk or benefits of receiving / not receiving blood or blood products have been discussed
- I have received an information brochure about blood transfusion
- The availability and appropriateness of any other blood management strategies have been discussed
- My questions have been answered

Yes = I confirm all of the above have occurred

No = Discuss with a member of staff prior to commencing / consenting to a transfusion.

**I consent** to having a transfusion of blood or blood products if required.

Signature: \_\_\_\_\_ Date of signature: DD / MM / YYYY  
Signature of patient / relative / guardian

**Or**

**I refuse** to have a transfusion of blood or blood products at this time.

Signature: \_\_\_\_\_ Date of signature: DD / MM / YYYY  
Signature of patient / relative / guardian

**Doctor to complete** - if patient is unable to complete any part of the consent, and there is no nominated enduring Power of Attorney (Medical) or relative / guardian immediately available.

**(For use in an emergency situation or when a patient is physically unable to sign).**

I \_\_\_\_\_ have discussed the proposed procedure / treatment  
Print name of Doctor

with \_\_\_\_\_  
Print name of person Relationship to patient

who has agreed that the procedure / treatment be undertaken.

Doctor's signature: \_\_\_\_\_ Date of signature: DD / MM / YYYY  
Signature of Doctor



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Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Affix patients label here  
 or complete details

## Pre-operative Medical Orders

### Allergies and drug reactions

 Yes  None known

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Drug substance	Reaction	Date	Drug substance	Reaction	Date
		/ /			/ /
		/ /			/ /
		/ /			/ /

Doctor to complete

**Patient to bring this form to hospital on day of admission**

**Treatment order on admission** (E.g. pre-warming, sequential compression device)

Doctor's name

Doctor's name

Doctor's signature

Doctor's signature

### Test on admission (E.g. ECG, Pathology)

Doctor's name

Doctor's name

Doctor's signature

Doctor's signature

### Preoperative medications only - to be given on admission (Eye drops, enema and topical preparations only)

Date prescribed	Medication order			Prescribing Doctor				Record of administration					
	Dose	Frequency	Route	Prescriber number	Doctor's name	Doctor's signature	Date	Time Given by	Time Given by	Time Given by			
/ /							/ /						
/ /							/ /						
/ /							/ /						
/ /							/ /						

