Cabrini

Please fill in your name and date of birth

Consent to Procedure or Surgical Treatment

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

FCH101201

Part A - To be completed by Treating Medical Practitioner

Interpreter used: ☑ Not required ☐ Yes If Yes, which language was the information translated to: _____

Interpreter service used: _____

Has anyone been appointed as a person responsible[1] for this patient's care? ☐ No ☐ Yes

If Yes, please specify who: _____

Does the patient have any written requests / requirements / instructions relating to their care[2]? ☐ No ☐ Yes

If Yes, please specify: _____

Where applicable, all written requests / requirements / instructions relating to the patient's care must be sighted

1. A person responsible may include an appointed medical treatment decision maker under the Medical Treatment Planning and Decisions Act 2016 (Vic) or a guardian with power to make medical treatment decisions appointed under the Guardianship and Administration Act 2019 (Vic)
2. Advanced Care Directives including any Instructional directives or Values directives under the Medical Treatment Planning and Decisions Act 2016 (Vic) or similar document

Description of the procedure or surgery, noting correct side / correct site. List all anticipated procedures or treatments (including the expected transfusion of blood or blood products and any possible secondary procedures).

Please fill in the name of the procedure

The risks of this procedure / treatment have been discussed with the patient and these include:

- Infection
- Bruising or bleeding
- Pain / swelling / scars
- Risks associated with anaesthesia / sedation (if applicable you will have the opportunity to discuss these in more detail prior to your procedure)
- Other (please specify including any risks specific to the patient):

Please see letter sent via Argus to Cabrini Hospital, accessable via the PAS or Clinicalviewer systems

To be completed by Treating Medical Practitioners

I have explained the nature and purpose of the procedure / treatment detailed above and what it entails for the patient, the known benefits and risks of the procedure / treatment, the risks of not having the procedure / treatment, and the alternatives to having the procedure / treatment.

Full Name: **Raymond Yap**_____

Name of **MEDICAL PRACTITIONER**

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **MEDICAL PRACTITIONER**

Allanby
CH1138
N/F
15/06/23

CONSENT TO PROCEDURE OR SURGICAL TREATMENT MR002DS

Cabrini

Please fill in your name and date of birth

Consent to Procedure or Surgical Treatment

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

FCH101201

Part B - To be completed by Patient or Person Responsible

I consent to the procedure and associated treatments as detailed in **Part A** of this form (overleaf).

In providing my consent to treatment, I acknowledge that the treatment has been explained to me by my treating medical practitioner and that I understand and have had the opportunity to ask questions about:

- The need for the procedure(s) or treatment(s);
- The known expected benefits and possible risks of the procedure(s) or treatment(s), including any risks specific to me;
- Alternative treatment options available and the expected benefits and possible risks of not having this procedure or treatment.

I further understand and agree to the following:

- My health information will be collected and used in accordance with Cabrini's Privacy Policy and applicable privacy laws.
- I may need additional procedure(s) / treatment(s) as is necessary in the reasonable opinion of my treating medical practitioner to preserve my health or life. This may include the transfusion of blood or blood products. **If you refuse the emergency / life-saving transfusion of blood or blood products, please notify your treating doctor so that your preferences can be documented.*
- If a staff member is exposed to my blood, a sample of my blood may be collected and tested for infectious diseases and that I will be informed of the test and results.
- Clinical information, including clinical photography / videography, blood or tissue specimens, may be collected during my procedure or treatment for diagnostic and treatment purposes. Additionally, this clinical information may be de-identified and used for the purpose of education and / or ethically approved research. **If you do not want your clinical information used in this way, please indicate your preferences below and notify your treating doctor:*

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of education.

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of ethically approved research.

Full Name: _____
Name of **PATIENT** or parent / guardian / person responsible

Please fill in your name

Signature: _____ Date of signature: DD/MM/YYYY
Signature of **PATIENT** or parent / guardian / person responsible

Please sign and date

Part C - Consent to the transfusion of Blood and Blood Products

(To be completed by Patient or Person Responsible, where indicated as appropriate by the treating Medical Practitioner. Strike out Part C if not applicable.)

Please fill in your name

I _____ have discussed the following with my doctor:
Name of **PATIENT** or parent / guardian / person responsible

- The likelihood that I require / may require a transfusion of blood or blood products in association with this treatment
- The reason(s) why I require / may require a transfusion of blood or blood products and the type of blood components and / or products required
- The general risks and benefits of receiving / not receiving blood or blood products
- The alternative treatments to having a blood transfusion and alternative blood management strategies

I have also been provided with written information about blood transfusions and have had the opportunity to ask my doctor any questions.

I understand the information provided to me and consent to the transfusion of blood or blood products as required, in association with the procedure / treatment outlined in **Part A** of this form (overleaf).

Please sign and date

Signature: _____ Date of signature: DD/MM/YYYY
Signature of **PATIENT** or parent / guardian / person responsible

**** If you REFUSE to consent to the transfusion of blood or blood products (or specific products) please discuss this with your treating doctor so that your preferences can be documented***