NSW GOVERNMENT Health

Facility:

FAMILY NAME CARTER	MRN 2811196
GIVEN NAME HELEN	☐ MALE ☒ FEMALE
D.O.B. 30 / 09 / 31	M.O. DAVID ROHR
ADDRESS	
LOCATION SURGICAL.	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

SMR020001

(For patients 14 years and above – not for Guardianship Act purposes.)

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr CINDY WO (insert name of medical practitioner) have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment:

(insert site name and reasons for procedure or treatment; do not use abbreviations)

RIGHT HEMI ARTHROPLASTY.

I have informed this patient of the matters detailed below including the nature, likely results, and material risks of the proposed procedure of treatment.

SIGNATURE OF MEDICAL PRACTITIONER	DATE 04 / 06 /20 18	TIME 1100
Interpreter present* SIGNATURE OF INTERPRETER	DATE / /20	TIME

PATIENT CONSENT — To be completed by Patient

Dr CINDY WO. (insert name of medical practitioner) and I have discussed the present condition and the various ways in which it might be treated, including the above procedure or treatment.

The doctor has told me that

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
I have been told that another doctor may perform the procedure/treatment.*
I **request and consent** to the procedure/treatment described above for me.

DELETE IF NOT REQUIRED — *This part must be countersigned by your doctor*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to have the following aspects of the recommended procedure or treatment: (insert objection)

(medical practitioner's acknowledgement)

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/do not consent*** to a blood transfusion if needed.

SIGNATURE OF PATIENT	DATE 04 / 06 /20 18
Helen Carter PRINT NAME OF PATIENT	TIME 1100
ADDRESS	

*delete where not applicable

NH606006 - 190813

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

SMR020.001

NO WRITING WP09_S2_CM26_CONSENT Continue overleaf...

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Facility:

FAMILY NAME	CARTER	MRN	2811196
GIVEN NAME	HELEN	☐ MALE	☒ FEMALE
D.O.B.	30 / 09 / 31	M.O.	DAVID ROHR
ADDRESS			
LOCATION	SURGICAL.		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

(For patients 14 years and above – not for Guardianship Act purposes.)

USE OF REMOVED TISSUE (SEE SECTION 33 of CIRCULAR)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of my condition.

I **consent**/**do not consent*** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

.....
insert terms, if any

This consent extends only to tissue, which is removed for the purposes of the above procedure.

.....
SIGNATURE OF PATIENT

04 / 06 /20 18
DATE

*delete where not applicable

NO WRITING

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR020001