NSW GOVERNMENT Health

Facility:

FAMILY NAME HANSEN	MRN 1707876
GIVEN NAME ROSE	☐ MALE ☒ FEMALE
D.O.B. 23 / 07 / 50	M.O. MILLS
ADDRESS	
LOCATION SURGICAL WARD	

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.)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr ANNA MILLS. (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)

LEFT MASTECTOMY WITH LEFT AXILLARY CLEARANCE.

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

A. Mills. (SIGNATURE OF MEDICAL PRACTITIONER)	27 / 05 / 20 18 (DATE)	0800 (TIME)
Interpreter present* (SIGNATURE OF INTERPRETER)	/ / 20 (DATE)	(TIME)

PATIENT CONSENT

To be completed by Patient

Dr ANNA MILLS (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.

Hansen (SIGNATURE OF PATIENT)	27 / 05 / 20 18 (DATE)
ROSE HANSEN (PRINT NAME OF PATIENT)	0800 (TIME)

ADDRESS

*delete where not applicable

NO WRITING WP05_S3_CM10_CON

Continue overleaf...

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GIVEN NAME	ROSE	☐ MALE	☒ FEMALE
D.O.B.	23 / 07 / 50	M.O.	MILLS
ADDRESS			
LOCATION	SURGICAL WARD.		

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

27 / 05 /20 18
DATE

*delete where not applicable

NO WRITING

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR020001