NSW GOVERNMENT | Health

Facility:

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

SMR020001

FAMILY NAME	RYAN	MRN	0428971
GIVEN NAME	ARTHUR	☒ MALE	☐ FEMALE
D.O.B.	08 / 10 / 53	M.O.	DR FRANCHESCA
ADDRESS			
LOCATION	VASCULAR WARD		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr LEONARDO FRANCHESCA (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 FEMORAL DISTAL BYPASS GRAFT w̄ LONG SAPHENOUS VEIN HARVESTING (LEFT).

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] SIGNATURE OF MEDICAL PRACTITIONER — DATE 15 / 07 /20 18 — TIME 0800

Interpreter present* .... SIGNATURE OF INTERPRETER — DATE ..../..../20.... — TIME ....

PATIENT CONSENT

To be completed by Patient

Dr LEONARDO FRANCHESCA (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
>
> [section struck through]

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.

A. Ryan — SIGNATURE OF PATIENT — DATE 15 / 07 /20 18

Arthur Ryan — PRINT NAME OF PATIENT — TIME 0800

ADDRESS ....

*delete where not applicable

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

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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:

NIL

insert terms, if any

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

A Ryan
SIGNATURE OF PATIENT

15 / 07 /2018.
DATE

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR020001

*delete where not applicable

NO WRITING