StVincent's LISMORE

REQUEST/CONSENT FOR MEDICAL PROCEDURE/TREATMENT

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

❑ Day Only

❑ In-Patient

❑ DOH
❑ DVA
❑ Workers Comp
❑ Private
❑ Uninsured

PAEDIATRIC

(For PARENTS/GUARDIANS of patients less than 16 years of age)

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

I, Dr..... have discussed with this patient's parent/guardian the various
INSERT NAME OF MEDICAL PRACTITIONER

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

.....

Planned CMBS Item Number(s).....

I have informed this **parent/guardian*** of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

..../...../20..... .....
SIGNATURE OF MEDICAL PRACTITIONER — DATE — TIME

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

PATIENT CONSENT — **To be completed by Parent / Guardian**

Dr..... and I have discussed the present condition of .....
INSERT NAME OF MEDICAL PRACTITIONER — INSERT NAME OF MINOR

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

I **request and consent** to the procedure/treatment described above for .....
INSERT NAME OF MINOR

I **also consent to a transfusion of blood and/or blood products** if needed.

..../...../20..... .....
SIGNATURE OF PARENT/GUARDIAN — PRINT NAME OF PARENT/GUARDIAN — DATE — TIME

OR

I **request and consent** to the procedure/treatment described above for .....
INSERT NAME OF MINOR

I **do not consent to a transfusion of blood and/or blood products** if needed.

..../...../20..... .....
SIGNATURE OF PARENT/GUARDIAN — PRINT NAME OF PARENT/GUARDIAN — DATE — TIME

BINDING MARGIN – DO NOT WRITE

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (PAEDIATRIC)

DELETE IF NOT REQUIRED *(This part must be countersigned by your doctor if retained)*

While I consent to the proposed procedure/treatment, after discussing this matter with the doctor, I refuse consent for my child to have the following aspects of the recommended procedure/treatment:

.....

insert objection

..... *Medical Practitioner's Acknowledgment* .....

I note that the Children and Young Person's (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

USE OF REMOVED TISSUE

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

I **consent/do not consent*** to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of .....'s 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.

..../...../20.....

SIGNATURE OF PARENT/GUARDIAN | PRINT NAME OF PARENT/GUARDIAN | DATE

BINDING MARGIN – DO NOT WRITE

*Delete where not applicable