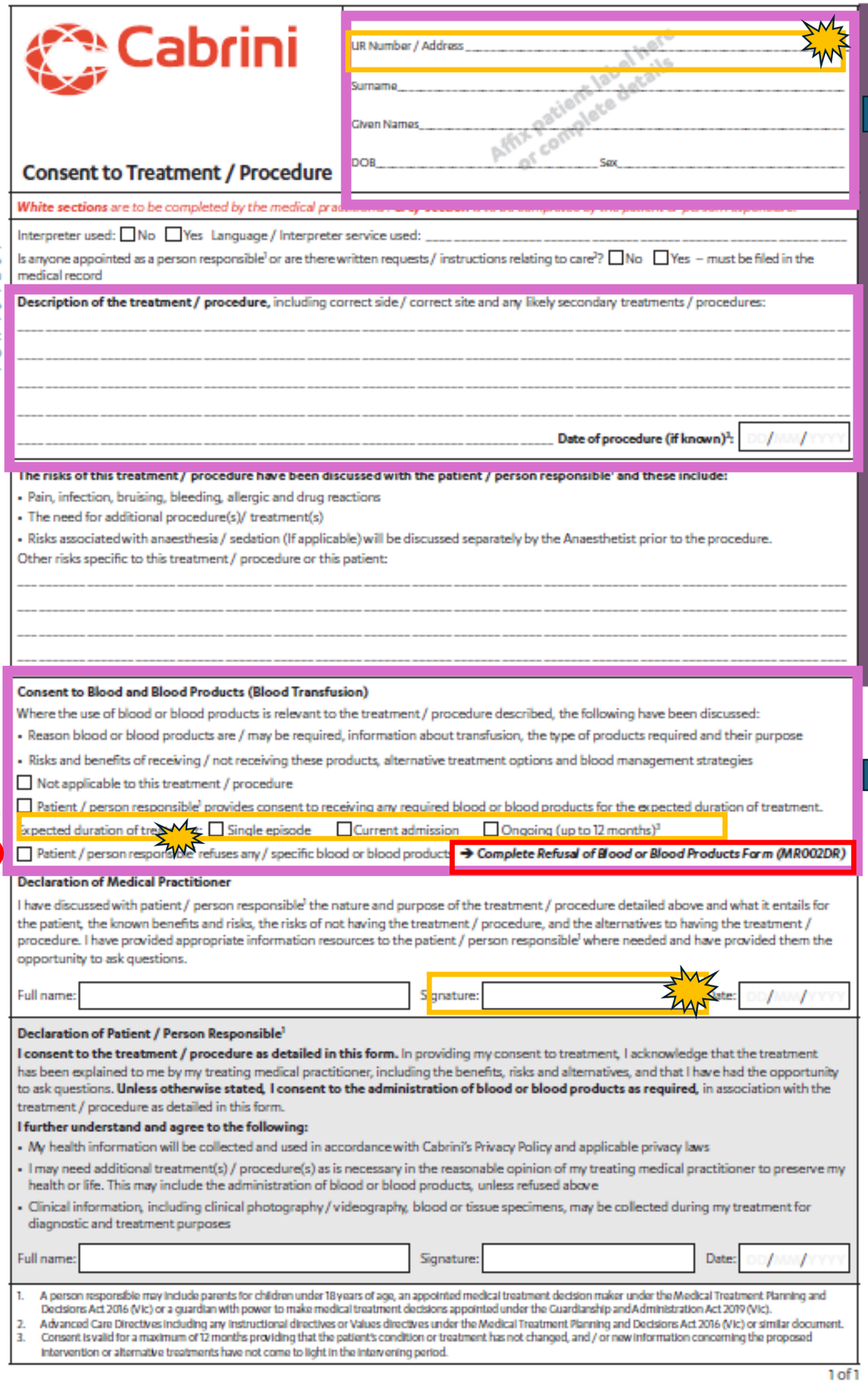
NEW VERSION OF CONSENT FORM



Cabrini

UR Number / Address

Surname

Given Names

DOB Sex

Affix patient label here or complete details

Consent to Treatment / Procedure

White sections are to be completed by the medical practitioner. Grey sections are to be completed by the patient or person responsible.

Interpreter used: ☐ No ☐ Yes Language / Interpreter service used:

Is anyone appointed as a person responsible[1] or are there written requests / instructions relating to care[2]? ☐ No ☐ Yes – must be filed in the medical record

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Date of procedure (if known)[3]: DD/MM/YYYY

The risks of this treatment / procedure have been discussed with the patient / person responsible[1] and these include:

- Pain, infection, bruising, bleeding, allergic and drug reactions
- The need for additional procedure(s)/ treatment(s)
- Risks associated with anaesthesia / sedation (If applicable) will be discussed separately by the Anaesthetist prior to the procedure.

Other risks specific to this treatment / procedure or this patient:

Consent to Blood and Blood Products (Blood Transfusion)

Where the use of blood or blood products is relevant to the treatment / procedure described, the following have been discussed:

- Reason blood or blood products are / may be required, information about transfusion, the type of products required and their purpose
- Risks and benefits of receiving / not receiving these products, alternative treatment options and blood management strategies

1 ☐ Not applicable to this treatment / procedure

2 ☐ Patient / person responsible[1] provides consent to receiving any required blood or blood products for the expected duration of treatment.

Expected duration of treatment: ☐ Single episode ☐ Current admission ☐ Ongoing (up to 12 months)[3]

3 ☐ Patient / person responsible refuses any / specific blood or blood products → *Complete Refusal of Blood or Blood Products Form (MR002DR)*

Declaration of Medical Practitioner

I have discussed with patient / person responsible[1] the nature and purpose of the treatment / procedure detailed above and what it entails for the patient, the known benefits and risks, the risks of not having the treatment / procedure, and the alternatives to having the treatment / procedure. I have provided appropriate information resources to the patient / person responsible[1] where needed and have provided them the opportunity to ask questions.

Full name: Signature: Date: DD/MM/YYYY

Declaration of Patient / Person Responsible[1]

I consent to the treatment / procedure as detailed in this form. In providing my consent to treatment, I acknowledge that the treatment has been explained to me by my treating medical practitioner, including the benefits, risks and alternatives, and that I have had the opportunity to ask questions. **Unless otherwise stated, I consent to the administration of blood or blood products as required,** in association with the treatment / procedure as detailed in this form.

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 treatment(s) / procedure(s) as is necessary in the reasonable opinion of my treating medical practitioner to preserve my health or life. This may include the administration of blood or blood products, unless refused above
- Clinical information, including clinical photography / videography, blood or tissue specimens, may be collected during my treatment for diagnostic and treatment purposes

Full name: Signature: Date: DD/MM/YYYY

1. A person responsible may include parents for children under 18 years of age, 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.
3. Consent is valid for a maximum of 12 months providing that the patient's condition or treatment has not changed, and / or new information concerning the proposed intervention or alternative treatments have not come to light in the intervening period.

lamby
©2002
V/F
04/24

CONSENT TO TREATMENT / PROCEDURE MR002D

1 of 1

FCH101201

Ensure all forms are sent to Cabrini/ Received by Cabrini with 3 patient identifiers.

Where the UR is unknown an address MUST be provided.

Description example: Not Acceptable

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Chemotherapy ✗

Date of procedure (if known)[3]: DD/MM/YYYY

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Excision of lesion -Finger ✗

Date of procedure (if known)[3]: DD/MM/YYYY

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Blood Transfusion ✗

Date of procedure (if known)[3]: DD/MM/YYYY

Description example: Acceptable

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

R-CHOP for treatment of Lymphoma ✓

Date of procedure (if known)[3]: DD/MM/YYYY

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Excision of lesion from right index finger ✓

Date of procedure (if known)[3]: 16/06/2024

Description of the treatment / procedure, including correct side / correct site and any likely secondary treatments / procedures:

Transfusion of Red Blood Cells for treatment of Anaemia ✓

Date of procedure (if known)[3]: 16/06/2024

The consent to Blood Transfusion Section is Mandatory for all patient's and one of the following 3 options MUST be selected

1 **Option 1: Blood transfusion will not be required and is Not Applicable**

2 **Option 2: The patient provides their consent to receive any necessary blood or blood products associated with the treatment/ procedure.**

Valid consent for blood or blood products must include the expected duration, This MUST be indicated.

e.g. surgical procedures should indicate single episode or current admission, whereas Oncology may wish to consent the patient to receive blood for up to 12 months in conjunction with treatment.

3 **Option 3: The patient expresses that they refuse some or all blood or blood products.**

The Refusal of Blood or Blood Products form(MR002D) MUST be completed and MUST be available and sighted in conjunction with the consent form.

– more details on Page 2 of this guide.

E-Signatures for Medical staff will be enabled on the editable pdf to make it easier for them to send in the forms.

NEW FORM – REFUSAL OF BLOOD/ BLOOD PRODUCTS

Ensure all forms are sent to Cabrini/ Received by Cabrini with 3 patient identifiers. Where the UR is unknown an address MUST be provided.

It is advised that this form be completed by a haematologist or by the medical practitioner in consultation with a haematologist. The Melbourne Pathology Haematologist can be reached where needed on *9508 1220*

Completing an Advance Care directive is also advised where there is any refusal of Blood or Blood Products

The description of the procedure or treatment should match what is printed on the consent form

Where completed in relation to a diagnosis, rather than specific treatment this should be accompanied with further documentation such as an advance care directive for further context.

This section should be completed by the appropriate medical practitioner involving the patient to document their preferences.

All field must either indicate Accept, Refuse OR N/A.

Where the patient 'accepts' this constitutes as consent to receiving the specific blood component or product

It is important that the reason for refusal is documented and that if there are any differing instructions in emergency or life-threatening situations that these are also documented.

E-Signatures for Medical staff will be enabled on the editable pdf to make it easier for them to send in the forms.

THIS FORM MUST BE COMPLETED WHERE A PATIENT REFUSES SOME OR ALL BLOOD/ BLOOD PRODUCTS

Cabrini

UR Number / Address

Surname

Given Names

DOB Sex

Affix patient label here or complete details

Refusal of Blood or Blood Products

Interpreter used: ☐ No ☐ Yes Language / Interpreter service used:

Is anyone appointed as a person responsible[1] or are there written requests / instructions relating to care[2]? ☐ No ☐ Yes – must be filed in the medical record

To be completed by a Haematologist / Medical Practitioner with the patient / person responsible[1]

Where the patient / person responsible[1] indicates any refusal of blood or blood products an Advance Care Directive should also be completed.

Description of medical treatment, procedure or diagnosis that may require the administration of blood, blood products or blood related procedures:

Date of procedure (if known): DD/MM/YYYY

Primary Blood Components	Accept	Refuse	N/A	Procedures involving my own blood	Accept	Refuse	N/A
Red Blood cells				Cell Salvage			
Fresh Frozen Plasma (FFP, plasma)				Renal Dialysis			
Platelets				Plasmapheresis			
White cells (Granuloytes)				Blood Radio-labelling			
Cryoprecipitate							
Products containing a minor blood fraction	**Accept**	**Refuse**	**N/A**	**Recombinant products**	**Accept**	**Refuse**	**N/A**
Albumin				rFVIIa (Novoseven)			
Intravenous Immunoglobulin				Erythropoietin			
Anti-D Immunoglobulin				Other e.g. FVIII			
Prothrombin Complex Concentrate (PCC)				**Other (Please specify)**	**Accept**	**Refuse**	**N/A**
Other Immunoglobulins e.g. Tetanus							

Reason for Refusal and Additional Comments: **Please document the specific reasons or circumstances surrounding the refusal and any additional comments that may be relevant to the decision, including instructions or preferences in emergency or life-threatening situations where they differ from above.**

Declaration of Medical Practitioner

I have discussed the need or potential need for blood or blood products with the patient / person responsible[1] and the risks of refusing such products. I have given the patient / person responsible[1] the opportunity to ask questions.

Full name: Signature: Date: DD/MM/YYYY

Declaration of Patient / Person Responsible[1]

I have discussed and documented my preferences regarding refusal or acceptance of blood or blood products with my doctor. This includes any instructions where my preferences differ in emergency or life saving situations. I can change my mind at any time, however, understand that the documented preferences will remain in force where I may be unconscious or incapable of expressing my wishes. I understand that where I have indicated acceptance of blood / blood products as above this constitutes my consent to recieving them.

Full name: Signature: Date: DD/MM/YYYY

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

REFUSAL OF BLOOD OR BLOOD PRODUCTS MR002DR