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 section*** *is 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]:

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

☐ Not applicable to this treatment / procedure

☐ 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]

☐ Patient / person responsible[1] 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:

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:

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.

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CONSENT TO TREATMENT / PROCEDURE MR002D