ST VINCENT'S PRIVATE HOSPITAL
TOOWOOMBA

Surname_______________
Given Names_______________
DOB__________ UR Number_______________

OR *Affix Patient Label*

INFORMED CONSENT TO TREATMENT FORM

PART A - DOCTOR TO COMPLETE

I, Dr ______________________________ have discussed with the patient / parent / guardian,

PATIENT'S NAME:______________________________

the patient's present condition, alternative treatments available, and explained the benefits and risks of the proposed operation / procedure.

The proposed operation / procedure is:______________________________

Other information provided to patient (optional):

Use back page if more space is needed

I have provided an opportunity to be asked questions by the patient.

PRINT NAME:.. SIGNED:.. DATE:.......................

PART B - PATIENT OR AUTHORISED PERSON/GUARDIAN TO COMPLETE

I HEREBY CONSENT to the performance of the procedure(s) / treatment(s) listed above on

☐ **Myself** ☐ **Other** ....
(Print patient's name and relationship)

I also request the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this operation / procedure.

I also consent to additional procedure(s) / treatment(s) which may be found necessary during the course of the aforementioned procedure(s)/treatment(s).

I understand that a sample of my blood may need to be tested if there is an injury to either my doctor or a hospital staff member during the proposed procedure / operation.

Although this operation / procedure will be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand the complications may occur with any operation / procedure and I accept the possible risks associated with this operation / procedure.

I have had the opportunity to ask questions about the operation / procedure and I am satisfied with the information I have received.

I acknowledge that as a teaching facility, there may be student health care professionals working under supervision who are involved in my care and I consent to this.

______________________________ ______________________________
Signature of patient/parent/guardian/other (specify below) *Date*

Specify other (PRINT): ______________________________

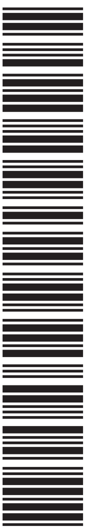
INTERPRETER / CULTURAL SUPPORT ATTESTATION

I have given a translation in .... *(state the language)* of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

____
Signature of interpreter/cultural support agent PRINTED NAME DATE TIME

Relationship to patient:______________________________

BINDING MARGIN



INFORMED CONSENT TO TREATMENT FORM

MRT 41AB

ST VINCENT'S PRIVATE HOSPITAL
TOOWOOMBA

INFORMED CONSENT TO TREATMENT FORM

Surname________________________________

Given Names_____________________________

DOB____________UR Number________________

OR *Affix Patient Label*

For Doctor's Use If Needed

Other information provided to patient (optional) - continued from front page

BINDING MARGIN

INFORMED CONSENT TO TREATMENT FORM

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