cura
day hospitals group

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Operation/Procedure Consent

Part 1 – to be completed by Accredited Health Practitioner

Information provided about the operation/procedure

Name of Patient:	Name of Patient's Substitute Decision-Maker (if applicable):
Name of Accredited Health Practitioner performing operation/procedure:	
The presenting symptoms or condition to be treated (if applicable):	
The proposed operation/procedure is:	
Proposed procedure date:	MBS item numbers:

Assessment of capacity to consent

I have assessed the capacity of the patient's ability to consent to the operation/procedure and have formed the view that:

☐ The patient **has** capacity to consent; *OR*

☐ The patient **does not have** capacity to consent, and so consent has been provided by the patient's:

.....

(insert relevant legal basis: parent, legal guardian, enduring power of attorney, statutory health attorney or substitute decision-maker)

Signature of Accredited Health Practitioner

I have discussed with the patient (or where the patient lacks capacity, the person who can legally make decisions on their behalf) the patient's condition, care options (including the proposed operation/procedure), the material risks of the options and any risks that are specific to the patient, the benefits of the options, the expected outcome of the proposed operation/procedure and the expected outcome of not undergoing the operation/procedure.

Signature of Accredited Health Practitioner:	Date:

Part 2 – to be completed by, or on behalf of, the patient

Consent to the operation/procedure

I request that the above operation/procedure be performed on the patient noted above.

By signing this form, I confirm and acknowledge that:

- I have been provided with information about my/the patients (a) condition and treatment options available; (b) the operation/procedure, and the risks and benefits of the operation/procedure; (c) the expected outcome of undergoing the operation/procedure and not undergoing the operation/procedure;
- I have had the opportunity to ask questions about the operation/procedure;
- the operation/procedure may involve the administration of anaesthetics, medicines, blood transfusions and/or other forms of treatment normally associated with the operation/procedure;
- if a complication arises during the course of the operation/procedure which requires urgent treatment to save my/the patient's life or prevent serious injury in circumstances where it is not practical to obtain consent, I/the patient will be provided with emergency treatment (which may include blood products) subject to the terms of any prior written and legally valid objection (including my/the patient's direction about the provision of blood below);
- a sample of my/the patient's blood may need to be taken and tested for infectious diseases if there is an injury to a doctor or staff member during the operation/procedure;
- there are risks associated with the operation/procedure including: (a) a worsening of my/the patient's condition; (b) other adverse outcome for me/the patient; (c) for screening procedures: not identify the condition being screened for; and (d) for therapeutic procedures, not improve my/the patient's condition or achieve an expected or desired outcome, despite it having been carried out with due professional care and responsibility, and I accept these risks;
- images or video footage may be recorded as part of, and during, my/the patient's operation/procedure, if these images or videos will assist the doctor to provide appropriate treatment;
- I have the right to change my mind and withdraw my consent at any time before the operation/procedure, preferably after discussion with my/the patient's doctor.

☐ I consent to the use of anaesthetic or sedation as required to perform the operation/procedure

☐ I consent to the use of blood products if they are required during my/the patient's operation/procedure

☐ I do **not** consent to images or video footage being recorded as a part of, or during the operation/procedure

☐ If applicable, I have been provided with a translator

Signature of Patient or Substitute Decision-Maker

Signature of Patient or Substitute Decision-Maker:	Relationship (if applicable)*:	Date:

**Relationship between the patient and person who can legally make decisions for the patient (e.g. parent, legal guardian, enduring power of attorney, statutory health attorney or person authorised by law to be a substitute decision-maker as relevant in the state/territory where this form is signed).*

DO NOT WRITE IN THIS BINDING MARGIN