On the day of your admission you must take all relevant paperwork, Xrays / MRI films etc with you.

Delmar private hospital

Consent Form

Request / Consent Form for Operation / Procedure and / or Medical Treatment

MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

Part A: Provision of Information to Patient (to be completed by Medical Practitioner)

I, Doctor ..... *(Insert name of medical practitioner)*,

have informed: ..... *(Insert name of patient / parent / guardian),*
of the nature, likely results, and material risks of the recommended operation / procedure and / or treatment. The agreed operation / procedure and treatment that the patient is to undergo is:

.....

.....

.....

(Insert name of operation / procedure and / or/ treatment))

....

Signature of Medical Practitioner *Date*

Interpreter required ☐ Yes ☐ No I, ..., an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to..... *(patient name)*

....

Signature of Interpreter *Date*

Part B: Patient Consent (to be completed by Patient)

The doctor, whose name appears in Part A above, and I have discussed my / my child's / my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of anaesthetic, medicines, and / or blood/blood products may be needed in association with this operation / procedure.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations / procedures and / or treatments being carried out if required, as long as they are related to the primary procedure set out in Part A.
- Even though the operation / procedure and / or treatment is carried out with all due professional care, the operation / procedure and / or treatment may not give the expected result.
- The operation / procedure and / or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature and risks of the procedure / operation / procedure treatment.

I have been advised of the material risks associated with this operation / procedure and / or treatment.

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

I understand that I may withdraw my consent at any time prior to the operation / procedure and / or treatment.

Part C: CONSENT TO OPERATION / PROCEDURE / TREATMENT

You are required to complete section 1) & have your signature witnessed by an adult who completes section 2).

Section 1

I request, understand and consent to the operation/ procedure and / or treatment as outlined above in Part A

(Signature of patient / parent / guardian) _____

(Print name of patient / parent / guardian) _____

Date ..... / ..... / .....

Section 2

I, the undersigned, witnessed the signing of section 1 above

Signature of witness _____

Print name of witness _____

Date ..... / ..... / .....

NOTE: If patient is under 14 years of age, parent or guardian must sign.

CONSENT FORM MR 6

Rev 9

DOCTOR'S REFERRAL FORM MR 5 Rev 9

Delmar private hospital

MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

Payment type & details ***(please tick)***

☐ **HEALTH FUND** ☐ **SELF FUNDED**
☐ **WORKERS' COMP** ☐ **DVA**
☐ **THIRD PARTY** ☐ **OTHER**

Doctor's Surgical Referral Form

To be completed by Doctor and faxed to Delmar on the day of Consultation: to **9982 7999**. Please PRINT clearly.

I request patient to attend Pre-Admission Clinic Yes ☐

Please Admit

Mr, Ms, Mrs, Miss, Master: .....Date of Admission: ..... / ..... / .....
Surname Given Names

Address: .....

Telephone: .... Date of Birth: ..... / ..... / ..... Sex .....
Home Business Mobile

Clinical Details

Presenting symptoms: .....

.....

Principal diagnosis, i.e., the condition which best accounts for patient's stay in hospital:.....

.....

Other conditions present: .....

.....

Medications:.....

.....

ALLERGIES:.....

SLEEP APNOEA: Does patient suffer from this ☐ Yes ☐ No Does patient use a CPAP Machine ☐ Yes ☐ No
If Yes, patient to take CPAP Machine to hospital

DEMENTIA: Does patient suffer from this ☐ Yes ☐ No

Does patient suffer from: **Confusion** ☐ Yes ☐ No **Mental Illness** ☐ Yes ☐ No **Incontinence** ☐ Yes ☐ No

Operation / Treatment Plan

Proposed Operation / Treatment .....

.....

Date of operation ..... / ..... / ..... **Item Numbers** .....

Type of Anaesthetic ..... **Expected length of procedure:** .....

Expected length of stay: ☐ Day Only, ☐ Overnight or longer .....days

Specific pre-operative instructions (including tests required):

☐ Anaesthetic Consultation .....

☐ Radiology: .....

☐ Pathology: .....

☐ Investigations: .....

☐ Drug orders on Admission: .....

☐ ECG: .....

☐ Special Instructions (e.g. bowel prep) .....

GP / Other Referring Doctor's Details

Name:..... Address:.....

Phone: .....