

IMPORTANT: Please send this completed form to the Centre where you will have your procedure/surgery.

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: / / Diagnosis: _____

Procedure/operation/treatment description: _____

Operative side of body: Left / Right / Bilateral / Not applicable *(please circle)*

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Admission details

Admission date: / / Admission time: _____ Procedure/Surgery date: / /
(If different to admission date)

Day stay unit Day inpatient Anticipated length of stay _____ hours

Admitting doctor's instructions: _____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner
(please circle)

Admitting doctor's signature: _____ Date: / /
(please circle)

(where applicable please attach evidence of enduring power of attorney)

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to have the procedure/operation/treatment described
(Patient's/Guardian's full name)

above performed on myself / my child _____ at _____
(please circle) (name of patient, if patient not signing form) (Centre where you will be having your procedure/surgery)

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment, and the possibility and nature of further related treatment including a return to theatre, should any complications arise.

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I have been provided with sufficient information by my doctor in relation to the administration of blood components / blood products if necessary. I give consent to the administration of blood or blood products if necessary: Yes No

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk e.g. Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to North Shore Surgical Centre or any health professional involved in my care for this admission, to access health information about me that is relevant to my current treatment, which may be held by North Shore Surgical Centre, other health professionals or other health organisations.

Patient/Guardian signature: _____ Date: / /
(please circle)

If not patient, state relationship to patient: _____

(where applicable please attach evidence of enduring power of attorney)

ANAESTHESIA PLAN AND CONSENT

Administration only
(Patient label)

THIS SECTION IS COMPLETED BY THE ANAESTHETIST

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Other: _____

Risk discussion

Sore Throat Nausea/Vomiting Dental Damage Allergic Reaction Itch Blood Clots
Block Failure Nerve Damage Headache Hypotension Rare Serious Events Pain Bleeding

Other: _____

Pain Relief Plan

Oral Intravenous PCA Epidural Spinal Wound Catheter Other

Discussion notes: _____

Anaesthetist Statement

I have discussed the proposed anaesthetic plan and possible alternatives with the:

Patient Parent/Guardian Spouse/Partner Next-of-Kin EPOA

Anaesthetist Name: _____ Date: ____ / ____ / ____
d m y

Anaesthetist Signature: _____

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)

myself / my child _____
(please circle) (name of patient if patient not signing form)

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had the anaesthesia.

Patient/Guardian signature: _____ Date: ____ / ____ / ____
d m y

If not patient, state relationship to patient: _____

(where applicable please attach evidence of enduring power of attorney)