NORTH SHORE SURGICAL CENTRE

Agreement To Treatment

IMPORTANT: Please send this completed form to the hospital 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: _____
dd mm yyyy

Procedure/operation/treatment description: _____

_____

_____

_____

Operative side of body: ☐ Left ☐ Right ☐ Bilateral ☐ Not applicable

Sedation: Yes ☐ No ☐ Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: ☐ general ☐ local ☐ regional ☐ spinal ☐ epidural

Admission details

Procedure/Surgery date: ____ / ____ / ____ Admission time: _____
dd mm yyyy

Day stay unit ☐ Day inpatient ☐ Anticipated length of stay _____ hours

Admitting doctor's instructions: _____

_____

_____

_____

_____

Admitting doctor's name: _____

Admitting doctor's signature: _____ **Date:** ____ / ____ / ____
dd mm yyyy

(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 North Shore Surgical Centre.
(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 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 (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by North Shore Surgical Centre, other health professionals or other health organisations.

Patient/Guardian signature: _____ Date: ____ / ____ / ____
dd mm yyyy

If not patient, state relationship to patient: _____

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

Please turn over

NORTH SHORE
SURGICAL CENTRE

Hospital Administration only
(Patient label)

ANAESTHESIA PLAN AND CONSENT

THIS SECTION IS COMPLETED WITH YOU BY THE ANAESTHETIST USUALLY ON THE DAY OF SURGERY

Proposed anaesthesia: General ☐ Local ☐ Regional ☐ Spinal/Epidural ☐ Sedation ☐
(Please tick)

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 ☐
ALL of the above discussed ☐

_____

_____

_____

Pain Relief Plan

Oral ☐ Intravenous ☐ PCA ☐ Epidural ☐ Spinal ☐ Wound Catheter ☐ PR ☐ Other ☐

Discussion notes: _____

_____

_____

_____

Anaesthetist's Instructions: _____

_____

_____

_____

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: ____ / ____ / ____
dd mm yyyy

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: ____ / ____ / ____
dd mm yyyy

If not patient, state relationship to patient: _____

(Where applicable, please attach evidence of enduring power of attorney)