TREATMENT (	CONSENT FO
(Adults and N	R MEDICAL F
Mature Minors)	AL PROCEDURE /

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<b>*</b>		FAMILY NAME		MRN
ISW Health		GIVEN NAME		☐ MALE ☐ FEMALE
acility:		D.O.B//	M.O.	
aciiity.		ADDRESS		
CON	ISENT FOR			
	EDURE / TREATMENT	LOCATION / WARD		
(Adults and Mature Minors)	COMPLETE ALL DETAIL	S OR AFFIX F	PATIENT LABEL HERE	
or patients with in doubt about the capac	h capacity  City of a minor, refer to section 8 of the C	Consent Manual for more information	n and/or escalat	te to a more senior colleague.
ROVISION OF INFO	RMATION TO PATIENT		To be complet	ted by Medical Practitioner
ne patient's present	have practitioner have condition including the following t	ng proposed procedure/trea	ıtment:	
(IN	SERT SITE NAME AND REASONS FOR PRO			
have informed this	patient of the nature, likely res			
nd of the motters in	the cestion below			
nd of the matters in have assessed this		acity to give consent (a 'ma	ture minor')	as they have
have assessed this	n the section below. Is patient to be a minor with cap ent maturity and intellect to ful			
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\* Delete where not applicable

NH606006 190319

NO WRITING

☐ I consent ☐ I do not consent to a blood transfusion if needed

PRINT NAME OF PATIENT

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SIGNATURE OF MEDICAL PRACTITONER

SIGNATURE OF PATIENT