NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors)

SMR020001

For patients with capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT — **To be completed by Medical Practitioner**

I, Dr ..... have discussed with this patient the various ways of treating
(INSERT NAME OF MEDICAL PRACTITIONER)
the patient's present condition including the following proposed procedure/treatment:

.....
(INSERT SITE NAME AND REASONS FOR PROCEDURE OR TREATMENT; DO NOT USE ABBREVIATIONS)
.....
.....
.....

I have informed this patient of the nature, likely results and material risks of the proposed procedure / treatment and of the matters in the section below.

I have assessed this patient to be a minor with capacity to give consent (a 'mature minor') as they have demonstrated sufficient maturity and intellect to fully understand what is proposed. ☐ Yes ☐ No ☐ NA

.... /..... /20..... ..... : .....
SIGNATURE OF MEDICAL PRACTITIONER — DATE — TIME

Interpreter* .... /...../20..... ..... : ....
PRINT NAME — SIGNATURE — DATE — TIME — Emp ID/Prov No.

PATIENT CONSENT — **To be completed by Patient**

Dr ..... and I have discussed the present condition and the various ways
(INSERT NAME OF MEDICAL PRACTITIONER)
in which it might be treated, including the above procedure or treatment.

The doctor has told me that:

- the procedure / treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or **blood transfusion may be needed**, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand the nature of the procedure / treatment and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
*I have been told that another doctor may perform the procedure/treatment.**
I **consent** to the procedure/treatment described above for me.
I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure / treatment.

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor as acknowledgment of refusal*
*While I consent to the above procedure/treatment, after discussing this matter with the doctor, I **refuse consent** to have the following aspects of the recommended procedure or treatment:*.....
insert objection
.....
....
SIGNATURE OF MEDICAL PRACTITONER

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

..../...../20.....
SIGNATURE OF PATIENT — DATE

.... : ..... AM/PM
PRINT NAME OF PATIENT — TIME

* Delete where not applicable

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors)

SMR020.001

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NO WRITING