NSW GOVERNMENT Health

Facility:

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (MINORS)

FAMILY NAME MRN

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020003

For parents / guardians of minors without 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's parent/guardian* the
INSERT NAME OF MEDICAL PRACTITIONER
various ways of treating the patient's present condition including the following proposed procedure/treatment:

.....
INSERT SITE AND NAME AND REASONS FOR PROCEDURE OR TREATMENT

.....
DO NOT USE ABBREVIATIONS

.....

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

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

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

PATIENT CONSENT — **To be completed by Parent/Guardian**

Dr ..... and I have discussed the present condition of .....
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF MINOR
and the various ways 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 .....
INSERT NAME OF MINOR
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** for my child to have the following aspects of the recommended procedure or treatment.*

.....
INSERT OBJECTION

....
SIGNATURE OF MEDICAL PRACTITIONER

I note that the Children and Young Persons (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

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

..../...../20.....
SIGNATURE OF PARENT/GUARDIAN DATE

....
PRINT NAME OF PARENT/GUARDIAN RELATIONSHIP TO CHILD OF PARENT/GUARDIAN

.....
ADDRESS

* Delete where not applicable

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

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (MINORS) SMR020.003

NO WRITING