Ramsay Health Care

# CONSENT FOR TREATMENT (PRIVATE)

UR: .....

Surname: .....

Given Names: .....

Date of Birth:..... Sex:.....

## PART A - PROVISION OF INFORMATION TO THE PATIENT
## To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed .....and/or
PRINT NAME OF PATIENT

..... / .....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) — RELATIONSHIP (FATHER, MOTHER/WIFE ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment: .....

.....

.....

.....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

Side of procedure/treatment: Left ☐ Right ☐ N/A ☐

.....
SIGNATURE OF MEDICAL PRACTITIONER — PRINT NAME — DATE

Interpreter present

.....
SIGNATURE OF INTERPRETER — PRINT NAME — DATE

## PART B - PATIENT CONSENT
## To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand blood products/blood transfusions carry some risk and complications may occur, which have been explained to me;
- I consent to* / do not consent* to blood products/blood transfusions, if needed;
  **(* DELETE WHERE NOT APPLICABLE)**

I **request and consent** to the procedure/treatment described above.

.....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE — DATE

.....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE — IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT EG; MOTHER / FATHER / HUSBAND

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DO NOT WRITE IN THIS BINDING MARGIN

Ver 7.0 - 02/17