FORM A

Patient Consent to Treatment or Investigation (Page 1 of 2)	**Affix hospital identification here**		
	Surname		**UMRN**
	Given names	**DOB**	**Sex**
	Address		
	Suburb		**Postcode**

This form is to be completed giving due consideration to the "*Consent to Treatment Policy for the Western Australian Health System*"

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

☐ I have informed the patient of the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications.

☐ I have recommended the treatment/procedures/investigations noted below on this form.

☐ I have explained the treatment/procedures/investigations, identified below, and what is entailed for the patient.

☐ I have provided the patient with information specific to the procedure identified. The patient has been asked to read information provided and ask the doctor/proceduralist questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient's medical record.

Information provided to the patient includes:

☐ **Open access procedures**
I have given the patient opportunity to discuss the proposed procedure, benefits and risks, both general and specific and the risk of not having the procedure.

☐ **Other procedures**
I have discussed the proposed procedure, benefits and risks, both general and specific, and the risks of not having the procedure.

Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires: ☐ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation

An anaesthetist will explain the risk of general or regional anaesthesia to you.

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:

Signature of doctor/proceduralist obtaining consent

Full name (please print)_________________________ **Position/Title**____________________

Signature________________________________ **Date**__________________________

Signature of doctor/proceduralist with overall responsibility for treatment (if different)

Full name (please print)_________________________ **Position/Title**____________________

Signature________________________________ **Date**__________________________

Patient Consent to Treatment or Investigation (Page 2 of 2)	**Affix hospital identification here**		
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Patient's declaration

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure ***prior to signing the consent form.***

☐ The doctor/proceduralist has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to me and associated risks, including the risks of ***not*** having the procedure.
☐ The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
☐ I **understand** that the result/outcome of the treatment/procedure cannot be guaranteed.
☐ I **understand** that if I am treated as a public patient, no guarantee can be provided that a particular doctor/ proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing training.
☐ I **understand** that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.
☐ If a staff member is exposed to my blood, I **consent** to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.
☐ I **agree** for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.
☐ I **understand** that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
☐ I **understand** that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
☐ I **consent** to undergo the procedure/s or treatment/s as documented on this form**.**
☐ I **consent** to a blood transfusion, if needed ☐ Yes ☐ No (***please tick appropriate box)***

Patient's full name____

Patient's signature____________________________ **Date/Time**____________

Parent/guardian signature____________________________ **Date/Time**____________
(if desired for mature minor)

Interpreter's declaration

Specific language requirements (if any) ____________________________

Interpreter services required: ☐ Yes ☐ No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

Interpreter's signature ____________________________ **Date**____________

Full name (please print) ____________________________

Confirmation of consent at pre-admission or admission to hospital

I confirm that the request and consent for the operation/procedure/treatment above remains current.

Patient's signature____________________________ **Date/Time**____________
(patient/person responsible)