

INTERPRETER: Yes No

Language:

Name: UR No.

Date of Birth:

Ward/Unit:
Affix Patient Label or Complete

OPERATION OR PROCEDURE

I (full name) _____

PATIENT OR LEGAL REPRESENTATIVE

agree that (operation or procedure) _____

Site: _____ Side: _____

Be performed on me / my child / ward _____ (full name of patient)

I have been able to discuss this with _____ Designation _____

NAME OF DOCTOR / PRACTITIONER

whose signature appears below. He/she has explained to me the reasons for and expected risks of the operation or procedure relating to my clinical history and condition. He/she has also informed me that (when appropriate) another competent practitioner may perform my operation or procedure.

I have had adequate opportunity to ask questions and have received all the information I want and I agree to this operation or procedure. I understand that I am welcome to ask for more information if I wish, and my consent may be withdrawn at any time.

■ I agree to have samples of my blood tested for transmissible diseases if a health worker is exposed to my blood.

Signed: Date:

PATIENT / LEGAL REPRESENTATIVE

Signed: Print Name:

DOCTOR / PRACTITIONER

Signed: Print Name:

INTERPRETER

Refresh:

I have had the opportunity to ask any further questions I have on the day of my operation or procedure and I confirm my agreement to this operation or procedure being undertaken.

Signed: Date:

PATIENT / LEGAL REPRESENTATIVE

Signed: Print Name:

DOCTOR / PRACTITIONER

Signed: Print Name:

INTERPRETER

BODY PART / BODILY SUBSTANCE / TISSUE

■ I wish to have any body part/tissue removed during this operation/procedure returned to me Yes No

ADDITIONAL INFORMATION (e.g. Notes, Diagrams)



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ANAESTHESIA

I have had the opportunity to read or had explained to me the Anaesthetic Information leaflet. I have had adequate opportunity to ask questions about the anaesthetic for the operation/procedure and have received all the information I want. This was provided by:

Dr: WHOSE SIGNATURE APPEARS BELOW Designation:

Description of anaesthesia procedure: (general / local / epidural / spinal / sedation)
Discussion:

The implications and possible risks of an anaesthetic because of my history, condition and the proposed surgery have been explained to me. I agree to receive this anaesthetic.

I acknowledge that for 24 hours after the operation having had a general anaesthetic and/or narcotic or sedative agent administered I should only take prescribed medications and should not:

- Drive a motor vehicle, nor operate machinery or potentially dangerous appliances
- Drink alcoholic beverages
- Make important decisions

Signed: PATIENT / LEGAL REPRESENTATIVE Date:

Signed: DOCTOR / ANAESTHETIST Print Name:

Signed: INTERPRETER Print Name:

BLOOD / BLOOD PRODUCTS

..... NAME OF DOCTOR / PRACTITIONER has discussed with me the possibility / high probability that I / my child may require the following blood products [*list the specific products /components discussed*]:

In relation to this operation or procedure:

- I have been given the relevant New Zealand Blood Transfusion Service pamphlet(s) entitled "Your Guide to Blood Transfusion" to read.
- I understand that I can ask questions or have more information in detail and that I can change this consent if I so wish.
- I agree / do not agree (cross out one) to receive such blood/blood products if considered necessary.

NOTE: This consent is for the total number of transfusions of blood/blood products required for your management.

Signed: PATIENT / LEGAL REPRESENTATIVE Date:

Signed: DOCTOR / PRACTITIONER Print Name:

Signed: INTERPRETER Print Name: