WESTERN
YOUR HOSPITAL THAT CARES

PRE-ADMISSION AND CONSENT TO OPERATE & NON OPERATIVE MEDICAL / DENTAL TREATMENT – BY PATIENT

Stick patient identification label in this box

UR No: _____

Surname: _____

Given Names: _____

DOB: _____ Sex: _____

Hospital/Health Unit Name: _____

(or affix patient label)

ACKNOWLEDGEMENT OF EXPLANATIONS

I, ...
(Given Names) *(Surname)*

have had explained to me by Dr: ..... on the nature, consequences and risks, both general and specific, of the following procedure(s) / treatment

.....

(Insert name(s) of particular procedure(s) / treatment including, if applicable, blood transfusion / administering blood products – indicate left or right side of the body where applicable – abbreviations are not to be used)

Being performed on: .....
(State Relationship, eg myself)

I acknowledge that the likely consequences of not undertaking the procedure(s) / treatment and any alternative treatment or courses of action that might be reasonably considered in the circumstances have also been explained to me. I have had an explanation of the potential risks associated with the procedure(s) / treatment, both general and in my specific situation as outlined by my Medical Practitioner.

CONSENTS

CONSENT TO PROCEDURE(S) TREATMENT

I have had the opportunity to ask questions and have understood the answers to my questions. I am satisfied with the explanations that I have been given. I consent to undergo the stated procedure(s) / treatment including blood transfusion / administration being performed at the same time, with the exception of the following (if applicable).

ACKNOWLEDGEMENT OF VISUAL RECORD FOR CLINICAL PURPOSES

I acknowledge that as a normal part of some procedure(s) / treatment, clinical photographs and/or video recordings may be taken of me to form part of my clinical record. I understand that these clinical photographs and/or videos will, as part of my clinical record, be kept confidential unless at a later time I give permission in writing for them to be included in published documents and/or to be used as educational material.

CONSENT AND ACKNOWLEDGEMENT RELATING TO BLOOD SCREENING

I also consent to, and understand the consequences of, a sample of blood being taken for infectious disease screening (including a HIV test) if a hospital staff member is exposed to my body fluids prior to, during or following the procedure(s) / treatment. I understand that should blood tests confirm that I am suffering from HIV or some other infectious disease, the tests will be reported to the **Department of Health in accordance with the Public Environmental Health Act**.

..../...../.....
(Patient / Guardian / Parent Signature) *(Medical / Dental Practitioner Signature)* *(Date)*

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WEST 007