CANOSSA PRIVATE HOSPITAL

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CONSENT TO PROCEDURE

HOSPITAL ADMINISTRATION SECTION ONLY

FAMILY NAME: *UR:*

FIRST NAMES:

DATE OF BIRTH: *GENDER:*

AFFIX PATIENT LABEL HERE

I, Dr _____ have discussed with the patient/parent/guardian the patient's present condition, alternative treatments available and explained the benefits and risks of the proposed operation/procedure which is _____

MEDICAL OFFICER'S SIGNATURE	

I (insert name), _____
request the above operation/procedure be performed on me.

OR

I (insert name), _____ as parent/guardian/EPOA
(circle appropriate response)
of (insert patient's name) _____
request the above operation/procedure be performed on them.

I also request the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this operation/procedure.

I understand that other unexpected operations/procedures may be necessary and I request that these be carried out if required.

I understand that a sample of blood may need to be tested if there is an injury to either my doctor or a hospital staff member during the proposed operation/procedure.

Although this operation/procedure will be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this operation/procedure and will be responsible for costs incurred.

I have had the opportunity to ask questions about the operation/procedure and I am satisfied with the information I have received.

Following surgery I will have a responsible adult accompany me home by motor vehicle and stay with me for up to 24 hours following surgery and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of anaesthesia and I will avoid making any decisions or taking part in activities which depend on full concentration, co-ordination or judgment for 24 hours.

Signature of Patient Or Parent/ Guardian	**Date:**
Specify relationship to patient	☐ Mother ☐ Father ☐ EPOA ☐ Other please state_____
A copy of the Enduring Power Of Attorney (EPOA) must accompany this consent form if there is one in place	

CONSENT TO PROCEDURE

CANOSSA PRIVATE HOSPITAL

CONSENT TO CARE

HOSPITAL ADMINISTRATION SECTION ONLY

FAMILY NAME: *UR:*

FIRST NAMES:

DATE OF BIRTH: *GENDER:*

AFFIX PATIENT LABEL HERE

CONSENT TO CARE: I consent to the staff of Canossa Private Hospital providing the following: Medications as ordered by my medical practitioner, physical therapies, physical Care including assistance with activities of daily living and mobility, other care and assistance reasonably incidental to the above.

I understand that I am responsible for providing accurate information in regard to my current private health insurance and am able to complete payment of all accounts associated with this admission.

I understand that in the event of an emergency I may need to be transferred to another medical facility for ongoing treatment and medical staff are not on site 24 hours/day.

I hereby release the hospital and hospital staff from all liability for any adverse results arising if I remove myself/this patient from the hospital at my own insistence and against the advice of the hospital staff and medical practitioner.

I agree, if I have made an advanced health directive, to provide a copy to Canossa Private Hospital. In the event I do not provide this document I accept the hospital may not have knowledge of my health decisions.

CONSENT TO USE PERSONAL INFORMATION:

In some cases the Australian Privacy Principles prohibit the use of personal information that Canossa Private Hospital collects and holds, if you do not consent to the use of such information. If you provide consent, the information will be used in a format where your identity will be clear in any material generated. You are under no obligation to provide consent to the use of your personal information. If you do not consent, we will respect your wishes and will inform you if this affects our ability to provide care and services to you. Our privacy policy is available on our website www.canossa.org.au and is available to view at our facility.

Please provide your consent to the use of your personal information for the purposes described below by signing this form. If you do not consent to any area write NO and sign beside the statement.

To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted them about. This may include a requirement to forward relevant prior information for example past medical history, pension details.

To inform next of kin of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.

To inform visitors of, and forward telephone enquiries and calls to, my location within the facility.

To assist Canossa Private Hospital in providing practical training and education to medical, nursing and other allied health students by accessing my health records and health information.

To enable Canossa Private Hospital to provide access to my information to the Health Fund of which I am a member if requested by the Health Fund to do so.

For research and development projects undertaken by Canossa Private Hospital in its own right or in conjunction with medical practitioners who work in the facility or with drug companies.

To communicate promotional material and special events to me.

I direct you NOT to provide my personal information to (please specify name/details):

_____

_____

SIGNATURE: _____ **Date:**_____

NAME OF PERSON SIGNING: _____(patient/parent/guardian/EPOA)