(Attach Patient Label or Complete Details)

NAME:_____ NHI:_____

SEX:_____ DATE OF BIRTH:_____ WARD:_____

Agreement to Medical Treatment

PATIENT AGREEMENT FOR BLOOD OR BLOOD PRODUCT TRANSFUSION

Health Professional: _____ _____
(Print name) (Print designation)

whose signature appears below has advised me that I / my child / my welfare guardian (WG) may require a blood or blood product transfusion.
(delete as appropriate)

Having had the opportunity to ask questions and discuss the possible risks and benefits and the alternatives to a blood or blood product transfusion with him/her, I AGREE / DO NOT AGREE to blood products EXCEPT:

_____

being administered to me / my child / my welfare guardian (WG) should the use of such be deemed necessary.
(delete as appropriate)

NZ Blood Service leaflet given to patient ☐ **Yes**

Signed: _____ _____
(Patient / Parent / EPOA / WG) (Date)

Signed: _____ _____
(Health Professional) (Date)

If blood or blood products are not required, cross out and write N/A

DECISION TO TREAT MADE BY ATTENDING MEDICAL PRACTITIONER

The decision to undertake a procedure or administer blood or blood product to a patient who is unable to provide consent or for whom there is no legal representative is ultimately the responsibility of the doctors caring for the patient. However, it is the Canterbury District Health Board's policy to consult, where practical, members of the patient's family, significant others and/or anyone else with a legitimate interest in the care of the patient in order to help determine what the patient's wishes might be.

I, Dr _____ _____
(Print Doctor's name) (Print designation)

Hereby certify that the condition of _____
(Print patient's name)

is such that consent can not be obtained prior to:

_____

_____ which I further certify is, in my opinion, in her/his best interests.

In reaching this opinion, I have taken into account information provided to me by others interested in her/his welfare, the signature of one of whom appears below as witness.

AND / OR (Delete as appropriate)

In reaching this opinion I have consulted with colleagues, the signature and name of whom appears below as witness.

Signed: _____ _____
(Doctor) (Date)

Signed: _____ _____ _____
(Patient's witness - sign and print name) (Relationship to patient) (Date)

Signed: _____ _____ _____
(Health professional witness - sign and print name) (Designation) (Date)

Notes for Staff
Procedure to be followed when the patient or legal representative cannot/is not available to provide consent:
In these situations, medical staff can undertake those measures which are in their opinion necessary and in the patient's best interests to save life or prevent permanent physical and mental injury and/or to prevent prolonged unavoidable pain and suffering, provided that:

1. Reasonable attempts have been made to obtain consent and taking the clinical situation and the time available into consideration.
2. They are in a position to document justification for proceeding without obtaining consent.
3. Where time permits the specialist having overall responsibility for the patient is aware of the proposed action.
4. Where appropriate and where time permits, the specialist-in-charge has sought a second opinion from another medical practitioner with appropriate experience.

In non-urgent situations, reasonable steps must be taken to ascertain what the patient's informed choice might be in the given circumstances. This may necessitate seeking opinion from others having an interest in the welfare of the patient. In this regard staff are referred to Right 7(4) of the Code of Health and Disability Services Consumers' Rights.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(Attach Patient Label or Complete Details)

NAME:_____ NHI:_____

SEX:_____ DATE OF BIRTH:_____ WARD:_____

AGREEMENT TO MEDICAL TREATMENT

The patient named above has a condition called _____

Statement of Health Professional

After discussion with the patient the following treatment has been recommended:

_____

I have explained this condition and its treatment to the patient and answered their questions at this time. In particular we have discussed:

- The benefits of the treatment
- The short term side effects of treatment
- The long term risks of the treatment
- Other treatment options including no treatment and private treatment options
- Supporting information resources.

Signed: _____ **Date:** _____

Name (PRINT): _____ **Designation:** _____

(Further documentation of the information on risks and side effects discussed with the patient can be found in the patient's clinical record.)

Statement of Patient / Legal Representative
(includes Person with Parental Responsibility / Enduring Power of Attorney (EPOA) or Welfare Guardian (WG))

I, the patient / legal representative agree to the treatment described above and wish to proceed.
(Delete as appropriate)

I understand I can change my mind at any time if I wish.

I have been given the time to ask questions and have received all the information I want at this stage.
I understand I am welcome to ask for more information.

I understand that should my / the patient's condition change, the treatment will be reviewed and discussed.
(Delete as appropriate)

I understand that the treatment will be performed by an appropriately qualified health professional.

I am aware that the CDHB is involved in the education of health professionals and therefore persons in training may be involved in my / the patient's care. I understand their presence can be declined.
(Delete as appropriate)

Signed: _____ **Date:** _____

Name (PRINT): _____ **Relationship: Patient / Parent / EPOA / WG**
(Delete as appropriate)

Interpreter Services: Interpreters are available for most languages likely to be encountered. Should there be any doubt as to the patient's ability to understand English, please contact the Customer Services Team 80843.

Language: I have interpreted the discussion to the patient / parent / EPOA / WG to the best of my ability and in a way which I believe they can understand.

Interpreter's Name: _____ **Signature:** _____ **Date:** _____

Confirmation of Agreement by Health Professional

I have confirmed that the patient / parent / EPOA / WG agrees they want the treatment to go ahead.

Checklist used: ☐ Yes ☐ No Checklist: _____

Signed: _____ **Date:** _____

Name (PRINT): _____ **Designation:** _____

AGREEMENT TO MEDICAL TREATMENT C130004