MIDCENTRAL HEALTH

PATIENT ID LABEL

BARCODE AREA

OPERATION/PROCEDURE CONSENT FORM

For patients deemed competent and/or minors. Please print clearly – use BLOCK LETTERS.

SECTION A – to be completed in all circumstances.

I *(name)* _____ agree to the following operation/procedure to be performed on:

* myself	OR on	* *(name of patient)* *(state relationship eg son, daughter)*

(Strike out option above that does not apply.)*

Name of the procedure and simple explanation:
(This should be written in by a medical practitioner and any relevant information sheet attached.)

_____

_____

I have discussed with _____
the benefits, risks and the likely results of this treatment and the alternative options to it.

The possible consequences of not receiving the proposed treatment have also been explained to me.

It is expected that the doctor(s) performing this operation will be _____ *(name)*
but in unforeseen circumstances, this may change.

I have special requests and/or instructions regarding my operation/procedure ..... YES NO

I do/do not give permission for _____
(Note above anything specific relating to the above.)

SECTION B – to be completed only if appropriate. Cross out if not applicable.

Blood Transfusions and Blood Products:

I have had the opportunity to read the attached blood product information sheet ..... YES NO

I give permission to receive transfusion of blood and blood products, if this is considered necessary .... YES NO

Tissue/Body Parts:

Tissue/body parts that have been removed
as part of my treatment may be used for research and/or teaching ..... YES NO

I have the following special request(s) regarding the return or disposal of any tissue/body parts
that are removed, as acceptable under New Zealand legislation:

_____

SECTION C – to be completed in all circumstances.

Signed: _____ Date: _____
(Patient or Representive)

I certify that this form was read over and the relevant procedures were explained by me to the signatory who signed it in my presence.

Signed: _____ Date: _____
(Doctor)

Information collected about you during your admission, will be used to provide you with healthcare, treatment and for purposes of administration. Information regarding accidents will be given to ACC. Statistical information will be used by MidCentral Health, Health Funding Authority and Ministry of Health. Information about you will be forwarded to your Primary Care Health Practitioner, any provider chosen to continue your treatment or your preferred contact, unless you indicate otherwise.

PTO for patients deemed incompetent

BINDING MARGIN – NO WRITING

MidCentral Health

PATIENT ID LABEL

OPERATION/PROCEDURE AUTHORISATION FORM

For patients deemed incompetent. Please print clearly – use BLOCK LETTERS.

Proposed procedure or operation _____

Purpose of proposed procedure or operation _____

_____

Patient determined to be incompetent on the basis of *(tick box, more than one category possible):*

	YES *(if yes, specify)*		*Details in medical record (✓)*
Pre-existing condition	☐	_____	☐
Current illness/injury	☐	_____	☐
Therapeutic intervention *(eg sedation)*	☐	_____	☐

Does the patient have a Welfare Guardian, or person with Enduring Power of Attorney? ..... YES NO *go to A*

(If YES, use the standard consent form.)

A. ASCERTAINING THE PATIENT'S VIEWS ABOUT THE PROPOSED TREATMENT:

Write details in medical record. (Tick box(es) as appropriate.)

These questions relate to the most recent expressions of views when the patient was competent.

1) Have the patient's specific views on this treatment been ascertained? ..... YES *go to 2* NO *go to 3*

2) Where the patient's specific views are ascertained, is the proposed treatment confirmed to be in accordance with patient's views/wishes? ..... YES *go to B* NO *do not proceed*

3) Where the patient's specific views have not been ascertained, it is necessary to take into account the views of other persons who are interested in the welfare of the patient and are available to advise.

   Have the views of other suitable people been taken into account? ..... YES *go to B* NO *go to 4*

4) Where the patient's views or other people's views have not been ascertained, this has been because of:

   - *Clinical urgency* ..... YES *go to B* NO *go to B*
   - *Appropriate person(s) not available for consultation* ..... YES NO

B. AUTHORISING DOCTOR

Taking all matters into consideration, I believe that the proposed treatment is in the best interests of the patient, and in so far as it has been able to be determined, I believe that the proposed treatment is consistent with the informed choice the patient is likely to have made if he or she were competent.

Name: _____ Signature: _____

Date: _____ Designation: _____

(Specialist, MOSS or Registrar only)

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