RAMSAY
HEALTH CARE

CONSENT FOR TREATMENT (PRIVATE)

UR:.....

Surname:.....

Given Names:.....

Date of Birth:..... Sex:.....

AFFIX ID LABEL HERE

PART A - PROVISION OF INFORMATION TO THE PATIENT
To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed..... and/or
PRINT NAME OF PATIENT

...../.....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) RELATIONSHIP (FATHER, MOTHER/WIFE ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment:.....

.....

.....

.....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS.

Side of procedure/treatment: Left ☐ Right ☐ N/A ☐

.....
SIGNATURE OF MEDICAL PRACTITIONER DATE TIME

Interpreter present .....
SIGNATURE OF INTERPRETER DATE TIME

PART B - PATIENT CONSENT
To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatments(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand blood products/blood transfusions carry some risk and complications may occur, which have been explained to me;
- I consent to* / do not consent* to blood products/blood transfusions, if needed;
  (*DELETE WHERE NOT APPLICABLE)

I request and consent to the procedure/treatment described above.

.....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE DATE

.....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT
EG; MOTHER / FATHER / HUSBAND

CONSENT FOR TREATMENT (PRIVATE) RHC0035D