

Consent Form

Important!

Please bring this consent form with you on your admission to hospital. Your Health Questionnaire and Admission forms should have been completed and submitted online before your admission. If you did not complete these forms online the actual forms will need to be delivered or scanned and emailed to reception as soon as your surgery date has been booked.

Email: reception@wakefield.co.nz

Admission Day	M T W T F S S <small>(circle one)</small>	Admission Date	<input type="text"/>
Admission Time	<input type="text"/>	Scheduled Date of Operation/Procedure	<input type="text"/>

Personal Details (patient to complete)

Personal details:

Title

Surname Given names

Preferred Name Date of birth Age NHI No:

Known as

Address

Postcode

Request for and consent to Anaesthesia

(do not sign until you have been assessed by your anaesthetist)

I (patient or guardian) have had explained to me the anaesthetic requirements associated with the procedure(s) as listed overleaf including the inherent benefits and risks of:

General Anaesthesia Epidural Anaesthesia Local Anaesthesia Intravenous Sedation Regional Nerve Block Other _____

I accept the recommendation of Dr regarding these options.

Patient/Guardian Signature **Date**

Anaesthetic Specialist Signature **Date**

Attach sticky label from Anaesthetic handout and sign once assessment completed

Please turn over for Medical and Surgical Consent

Patient name:

Surname Given names

Operation/ Procedure

(specialist to complete)

Date of Birth

Diagnosis	<input type="text"/>	
Medical Treatment	<input type="text"/>	
Operation/ Procedure	<input type="text"/>	
Approximate Length of Stay	<input type="text"/> Hours	<input type="text"/> Nights

The treatment/procedure I intend to perform on / / is correctly described above.

Name of person performing planned course of treatment/procedure(s)

Specialist Signature

Date

Request for Treatment Procedure(s) (patient to complete after consultation with specialist)

I (patient or guardian)

	Yes	No	N/A
Understand the nature of, benefits and risks of the above treatment and/or procedure(s). I have had explained to me the alternative treatment and/or procedure(s) available, including not having any treatment. I have had the opportunity to ask my questions about the above treatment and/or procedure(s). I am aware that I may ask for more information at any time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agree that should unexpected findings be made during the treatment/procedure(s), additional procedures deemed to be essential might be carried out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agree to my blood being taken for testing in the event of blood or body fluid exposure to a staff member.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand and agree that tissue removed at the time of the treatment/procedure(s) may be submitted for pathological examination and retained or be disposed of. These specimens may be referred to at a later date for clinical purposes, audit or teaching purposes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand and agree that video and sound recordings and photographs may be made and stored confidentially, and may be referred to at a later date for teaching purposes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand that the tissue may be returned to me if I wish (a tissue form is required).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand that Wakefield Hospital provides teaching for medical and nursing staff and agree to observation of and participation in my treatment and/or procedure(s) by students under appropriate supervision.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONSENT FOR BLOOD OR BLOOD PRODUCTS Understand the nature, benefits and risks of receiving blood components/blood products and agree to receiving these if clinically necessary and in my own best interests.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient/Guardian Signature

Date