

Alerts

## CONSENT AND AGREEMENT TO TREATMENT

I, \_\_\_\_\_ request that the procedure/treatment of

\_\_\_\_\_ be performed on me/my child (under 16 yrs)/relative \_\_\_\_\_

I have been able to discuss this with Dr \_\_\_\_\_ whose signature appears below.

*Some health practitioners who use these facilities also hold an ownership interest in this hospital. This will not affect clinical decisions about your treatment. If you have any questions, please speak to your doctor or surgeon.*

I understand the reasons for the procedure, and the possible risks relating to this have been explained.

I agree to the administration of intravenous sedation, general anaesthetic and/or local anaesthetic as indicated.

I agree to the administration of blood/blood products if required.

I understand I will be able to discuss these details with the Anaesthetist and/or Specialist prior to the procedure.

I understand that, if instructed by my Specialist/this facility, I will arrange a responsible adult to take me home after treatment and to stay with me until the next day.

I understand that for my procedure to be done safely there may be extra equipment needed to enable the completion of the procedure.

I have had adequate opportunity to ask questions and I have received all the information I want.

I consent to the administration of Section 29 drugs if they are required, and I consent to my personal information being given to Medsafe if Section 29 drugs are administered.

I understand and agree to Shore Surgery Specialist Day Hospital or any health professional involved in my care for this admission, accessing and sharing health information about me that is relevant to my current treatment. This includes information relevant to my current treatment held by Shore Surgery Specialist Day Hospital, for other health professionals, other health organisations and relevant agencies such as ACC, MOH & my insurer.

Activated EPOA documentation including the doctors certificate to accompany this Consent form, if applicable and signed only by EPOA Delegated Authority.

SIGNED: \_\_\_\_\_ (PATIENT/EPOA/GUARDIAN)      DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_ (SHORE SURGERY SPECIALIST)      DATE: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_ Arrival time: \_\_\_\_\_