St Vincents
Private Hospital Lismore

Date of Admission:
Date of Surgery:

PRE – ADMISSION CLINICAL REFERRAL

TO BE COMPLETED BY THE MEDICAL OFFICER

Surname: ________________________ First Name: ________________________ D.O.B: ___________________

Attending Medical Officer: ____

Provisional Diagnosis: ____

Proposed Operation/Treatment: ____

Explained to patient and consent complete: ❑ Estimated Operating Time: _____ Hours ____ Minutes

LENGTH OF STAY: Please note all patients will be admitted **day of procedure** unless suitable reason provided.

❑ Admit _____ day/s prior to procedure. **Reason:** ____

❑ **DAY ONLY SURGERY** ____

❑ **1 NIGHT** (Extended Day Only 23 hours) ____

❑ **> 1 NIGHT Est. Length of Stay ______ Nights**

ANAESTHETIC INFO: Please note all patients will remain on **ASPIRIN** unless otherwise advised.

❑ Suitable for Local Anaesthesia ❑ HDU Bed required

❑ Cease Warfarin/Pradaxa _____ Days Preop ❑ Cease Clopidogrel _____ Days Preop

This patient requires a pre-operative anaesthetic consult Yes ❑ No ❑

ALLERGIES (Drugs, Latex, Dressings):

CO-MORBIDITIES:	**CURRENT MEDICATIONS**

INVESTIGATIONS REQUIRED (apart from routine Preop guidelines):

OTHER PREOP INSTRUCTIONS / TREATMENT ON ADMISSION / EQUIPMENT REQUIRED:

Signature: ______________________________________ Date: ______________________________

BINDING MARGIN - DO NOT WRITE

LNDMF0016-3 Rev Nov 13

St Vincents
Private Hospital Lismore

REQUEST/CONSENT FOR MEDICAL PROCEDURE/TREATMENT

Affix Patient Label Here

☐ Day Only
☐ In-Patient

☐ DOH
☐ DVA
☐ Private
☐ Uninsured

ADULT

(For patients 16 years and above – not for Guardianship Act purposes)

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr.. have discussed with .... the various ways
INSERT NAME OF MEDICAL PRACTITIONER — INSERT NAME OF PATIENT
of treating the patient's present condition including the following proposed procedure/treatment

....

....

I have informed the patient of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

PATIENT CONSENT — To be completed by Patient

The doctor and I have discussed my present condition and the various ways in which it might be treated, including the proposed procedure or treatment.

The doctor told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or transfusion of blood/blood products may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*****I have been told that another doctor may perform the procedure/treatment.*

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

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/do not consent*** to the recording of medical/surgical images on DVD or photograph.

*Delete where not applicable

SIGNATURE OF PATIENT/GUARDIAN	PRINT NAME OF PATIENT/GUARDIAN	....../....../20...... DATE	TIME
SIGNATURE OF MEDICAL PRACTITIONER	PRINT NAME OF MEDICAL PRACTITIONER	....../....../20...... DATE	TIME
Interpreter present*	SIGNATURE OF INTERPRETER	....../....../20...... DATE	TIME

LNDMF0016-4 Rev Oct 13

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REQUEST / CONSENT FORM

DELETE IF NOT REQUIRED *(This part must be countersigned by your doctor if retained.)*

While I consent to the proposed procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure/treatment:

....

.... *Medical Practitioner's Acknowledgment* ....

BLOOD AND BLOOD PRODUCTS

I, Dr .... confirm that I have explained to the patient/person legally
INSERT NAME OF MEDICAL PRACTITIONER
responsible that the transfusion administration of the following blood and/or blood products may be required:

☐ Fresh blood components ☐ Red blood cells ☐ Platelets
☐ Fresh frozen plasma ☐ Cryoprecipitate

I have explained the:

☐ Purpose of giving blood and/or blood product(s) ☐ Type of blood and/or blood product(s) to be given
☐ Possible risks associated with administration ☐ Available alternatives
☐ Possible risks of non-administration

I have ☐ or have not ☐ provided the brochure: *"Blood Transfusion: Have all your questions been answered?"* to the patient or person responsible.

..../............../20.............. ....
SIGNATURE OF MEDICAL PRACTITIONER DATE TIME

I, ... have had the reason for transfusion explained to me.
PRINT NAME OF PATIENT/GUARDIAN
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

I ☐ give consent ☐ do not consent ☐ refuse consent to blood and/or blood products as specified above to be transfused to myself or to

.... who is my .... as required.
PRINT NAME OF PATIENT RELATIONSHIP TO PATIENT

..../............../20.............. ....
SIGNATURE OF PATIENT/GUARDIAN PRINT NAME OF PATIENT/GUARDIAN DATE TIME

USE OF REMOVED TISSUE

I understand that the proposed procedure may involve the removal of some bodily tissue which may be required for the diagnosis or management of my condition.

I **consent/do not consent*** to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

....
INSERT TERM, IF ANY
This consent extends only to tissue, which is removed for the purposes of the above procedure.

..../............../20.............. ....
SIGNATURE OF PATIENT/GUARDIAN PRINT NAME OF PATIENT/GUARDIAN DATE TIME

*Delete where not applicable

BINDING MARGIN - DO NOT WRITE

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