Vermont Private Hospital

nexus

INFORMED CONSENT TO TREATMENT

PLEASE COMPLETE PATIENT DETAILS HERE

Surname: .... D.O.B: ...../...../......

Given Name: .... Gender: ....

Doctor: ....

PART A – TREATING DOCTOR TO COMPLETE

I, ... have personally explained to the;
(Name of practitioner performing procedure)

☐ **Patient** or ☐ **Guardian / Authorised substitute decision maker** ....
(Print name of Guardian / substitute decision maker)

the nature and effect of the operation(s) / procedure(s) listed here;

....

....

The procedure is to be performed on the ☐ **LEFT SIDE** ☐ **RIGHT SIDE** ☐ **BILATERAL** ☐ **N/A**

Additional notes: ....

Signature of doctor .... **Date:** ..../......../.............

PTO TO RECORD MEDICATION TO BE ORDERED ON ADMISSION

PART B - PATIENT TO COMPLETE OR GUARDIAN / AUTHORISED SUBSTITUTE DECISION MAKER

If the patient is deemed to have impaired decision making capacity or if the patient is a child, this document is to be read and signed by the person legally responsible for medical and surgical decisions of the patient and is to be present on the day of operation / procedure.

I hereby confirm that I have given consent to ....
(Name of specific practitioner performing procedure)
to perform the operation(s) / procedure(s) listed above on;

☐ **Myself** or ☐ **The patient** ....
(Print patient name)

- I understand the nature of the operation(s) / procedure(s) detailed to my satisfaction, and I consent to these and also to the administration of anaesthesia associated with this procedure(s).
- I also consent to additional procedure(s) / treatment(s) / anaesthesia which may be found necessary during the course of the above mentioned procedure.
- ☐ **I do** ☐ **I do not** (please select) consent to the administration of blood or blood products and I have notified my doctor and am aware of the risks, benefits and alternative options.
- I further consent to the use and disclosure of health information deemed necessary for my healthcare, or for purposes of audit of medical records.
- I understand that I am responsible for adhering to pre and post-operative instructions and the need for a carer to take me home and stay with me overnight.

I understand that following general anaesthetic / intravenous sedation there may be impairment of my mental alertness. I understand that I should not drive my car nor take part in any activities which depend upon full concentration or judgment for 24 hours following my procedure, general anaesthetic or intravenous sedation.

.... **Date:** ..../......../.............
(Signature of patient or Guardian / Authorised substitute decision maker)

.... Relationship to patient: ....
(Print name) (if applicable)

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PLEASE COMPLETE PATIENT DETAILS HERE

Surname: ………………………………………………… D.O.B: …../…../……

Given Name: …………………………………………. Gender: ……………..

Doctor: ……………………………………………………………………………..

Treating doctor - Please complete the below medication order if the patient requires pre-operative medication.

MEDICATION TO BE ORDERED ON ADMISSION – SURGEON TO COMPLETE WHERE REQUIRED								
Date	Drug	Dose	Route	Frequency & Duration	Doctor's Signature	Record of Administration		
						Date Given	Time Given	Given By