CONSENT FOR OPERATION/PROCEDURE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PATIENT DETAILS

Patient Name: Date of Birth: / /

Date of Admission: / / Time:

Referring Consultant:

ACC Contract ACC Non-Contract Surgeon Lead Provider Surgeon Contract, Non-Contract MercyAscot Lead Provider

CONSULTANT TO COMPLETE

Diagnosis:

Planned Operation/Procedure:

Proposed Date of Surgery: / / Operation Length: Length of Stay:

Body Side: Left Right Inpatient: Day Case:

I have explained to the benefits and risks of the above planned operation/procedure.

Surgeon's Name: Signature: Date: / /

PATIENT TO COMPLETE

I agree that I have received a reasonable explanation of the intent, alternatives, risks and likely outcomes of the operation/procedure of

to the

brief procedure description left/right

side of my body. In the event that something unexpected is found during surgery, I authorise the surgeon to act in my best interest.

I agree to the collecting of personal and health information from myself or my representative and authorise use of this information for purposes related to my health care.

In the event of a staff member receiving a 'needle stick injury' or other 'blood accident' from instrumentation used during my operation/procedure, I consent to a blood sample being drawn from myself and tested for HIV (the AIDS virus), Hepatitis B, Hepatitis C and any other blood test deemed necessary by my doctor. I understand I will be informed of such testing and the results if I request them.

Patient/Guardian Signature:
(Please circle one).

Date: / /

STAT MEDICATION ORDERS ON ADMISSION

Date	Drug	Dose	Route	Time	Authorised By	Given By	Time

Other preparations required (e.g. TEDs/SCDs), please specify:

INVESTIGATION REQUIRED

Please tick either: A = Prior to Admission, B = On Admission, C = Not Required

	A	B	C		A	B	C		A	B	C		
Electrolytes				Coag Screen				MSU				Ordered at Labtests	
Routine Haematology				Group & Ab Screen				ECG				Ordered at other lab	
Urea & Creatinine				Cross match ____units									
(Other) _____				(Other) _____				X-rays (state)					

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE
(SEE PAGE 4 OF PATIENT INFORMATION BOOKLET)