

Consent Form



BOWEN
HOSPITAL

A DIVISION OF



WAKEFIELD HEALTH
LIMITED

Important!

Please deliver, post, fax or email this form 7–10 working days before your admission together with the completed Health Questionnaire and Admission Form to:

Bowen Hospital
98 Churchill Drive
Crofton Downs
Wellington 6035

A stamped, addressed envelope is provided

Fax (04) 479 8520
Email admissions@bowen.co.nz

If this is not possible, please make sure you bring the forms with you when you arrive for admission.
If you faxed or emailed the forms to us, please bring the originals with you.

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

Personal Details (patient to complete)

Patient name:

Mr/Ms/Mrs/Miss/Dr

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

I accept the recommendation of Dr regarding these options.

Patient/Guardian Signature Date

Anaesthetic Specialist Signature Date

Please turn over for Medical and Surgical Treatment Consent

Attach sticky label from Anaesthetic handout and sign once assessment completed

Operation/Procedure (specialist to complete)

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
Admitting Specialist	<input type="text"/>			
	<small>Print Name</small>			

Request for and Consent to Medical and Surgical Treatment

(patient to complete after consultation with specialist)

I (patient or guardian) agree that I have had an explanation to my satisfaction of the intent, risks, complications and likely outcomes of the operation/procedure/treatment I am receiving.

I consent to having blood tested for HIV/Hepatitis B/Hepatitis C in the event of a staff member or doctor is exposed to my blood Yes No

I am aware that I may ask for more information about treatment at any time.

I accept the advice of my specialist and ask that the above treatment be carried out.

Patient/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
Admitting Specialist Signature	<input type="text"/>	Date	<input type="text"/>

Consent for Blood Products (patient to complete)

I consent / I do not consent *(circle as appropriate)* to being given blood and/or blood products.

I have been provided with the NZBS leaflet and all my questions have been answered to my satisfaction Yes No

Patient/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
Specialist Signature	<input type="text"/>	Date	<input type="text"/>

Advance Directive (patient to complete if required)

(tick appropriate boxes and provide a copy)

Living Will/Advance Directive Enduring Power of Attorney Do Not Resuscitate Order