

Consent Form



BOWEN
HOSPITAL

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

A stamped, addressed envelope is provided.

If it is not possible to send the form within 7–10 working days prior to your admission, please make sure you bring the forms with you on 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

Admission Time

Scheduled Date of Operation/Procedure

Personal Details (patient to complete)

Patient name:

Mr/Ms/Mrs/Miss/Dr

Surname

Given names

Preferred Name

Known as

Date of birth

Age

NHI No

Address

Postcode

Advance Directive: tick all relevant boxes (if enacted, please provide a copy of the documents/)

Advance Directive/Living Will

Enduring Power of Attorney for Health & Welfare

Do Not Resuscitate Order

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

Attach sticky label from Anaesthetic handout and sign once assessment completed

Please turn over for Medical and Surgical Consent

Patient name:

Mr/Ms/Mrs/Miss/Dr

Surname

Given names

Operation/Procedure (specialist to complete)

Date of Birth

Diagnosis

Medical Treatment

Operation/Procedure

Approximate Length of Stay

Hours

Nights

The treatment/procedure I intend to perform on / / is correctly described above.

Name of person performing planned course of treatment/procedure(s)

Specialist Signature

Date

Request for Treatment Procedure(s) (patient to complete after consultation with specialist)

I (patient or guardian)

(print name)

Understand the nature of, benefits and risks of the above treatment and/or procedure(s). I have had explained to me the alternative treatment and/or procedure(s) available, including not having any treatment. I have had the opportunity to ask my questions about the above treatment and/or procedure(s). I am aware that I may ask for more information at any time.

Yes	No	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Agree that should unexpected findings be made during the treatment/procedure(s), additional procedures deemed to be essential might be carried out.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Agree to my blood being taken for testing in the event of blood or body fluid exposure to a staff member.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Understand that tissue removed at the time of the treatment/procedure(s) may be submitted to the laboratory for pathological examination and retained or be disposed of. These specimens may be referred to at a later date for clinical purposes, audit, and/or teaching.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Understand that the tissue may be returned to me if I wish (a tissue form is required).

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Understand the nature, benefits and risks of receiving blood components/blood products and agree to receiving these if clinically necessary and in my own best interests.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Understand and agree that video and sound recordings and photographs may be made and stored confidentially, and may be referred to at a later date for teaching purposes.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Understand that Bowen Hospital provides teaching for medical and nursing staff and agree to observation of and participation in my treatment and/or procedure(s) by students under appropriate supervision.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Patient/Guardian Signature

Date