

Affix Label Here

Randwick Day Surgery

CONSENT TO OPERATIVE TREATMENT

I, _____ request and hereby consent
Print name in full

for the following procedure to be performed _____

on myself / my child _____
(circle appropriate) **Print name of child in full, if applicable**

Following a discussion of my present condition, I accept the professional opinion of

Dr. _____ that this is the appropriate procedure / treatment for my condition. I understand the nature, effects and costs of the procedure and these have been explained to me.

I accept the possible risks associated with this procedure / treatment. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers given to me. I agree to such further or alternative treatment as may be found necessary as a consequence of such a procedure, and for my blood to be taken for serology in the event of a needlestick or sharps injury that occurs during my admission.

I also consent to the administration of general anaesthesia/ intravenous sedation and/or local anaesthesia, for this purpose. I also agree to have any medicines or other treatments normally associated with this procedure. I understand that unexpected procedures are sometimes necessary and agree to these if they become urgently required. I understand that drowsiness may persist for at least 24 hours after anaesthesia. I will not drive a car or drink alcohol and will avoid making important decisions (e.g. signing of legal documents) until the next day. Following the procedure I will have a responsible adult to supervise my return home and to stay with me until the following day. I have made arrangements for this. If I do not comply with this and leave the Surgery unaccompanied I understand that I do so at my own risk and against medical advice.

I understand that Randwick Day Surgery has attempted to give an accurate estimate of costs. I acknowledge that I am responsible for any further fees as a result of additional procedures or in the event that my health insurance refuses to cover any or all of the costs related to my admission at the day surgery or subsequent hospital treatment.

Your well being is our primary concern and we will do everything we can to assure that the necessary care is given.

SIGNATURE OF PATIENT / GUARDIAN _____ **Date** _____

PRINT NAME OF PATIENT / GUARDIAN _____

PROVISION OF INFORMATION TO THE PATIENT To be completed by the Medical/Dental Practitioner

I, Dr. _____ have informed this patient / guardian as detailed above, including the nature, likely results and relevant foreseeable risks of the recommended procedure / treatment.

SIGNATURE OF PRACTITIONER: _____ **Date:** _____