# Consent Form

Bowen HOSPITAL

## Important!

**Please deliver, post 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*

*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 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 Date of birth Age NHI No:

*Known as* *If known*

Address

*Postode*

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

☐ 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*

## Operation/Procedure (specialist to complete)

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)*

| | Yes | No | N/A |
|---|---|---|---|
| **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. | ☐ | ☐ | ☐ |
| **Agree** that should unexpected findings be made during the treatment/procedure(s), additional procedures deemed to be essential might be carried out. | ☐ | ☐ | ☐ |
| **Agree** to my blood being taken for testing in the event of blood or body fluid exposure to a staff member. | ☐ | ☐ | ☐ |
| **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. | ☐ | ☐ | ☐ |
| **Understand** that the tissue may be returned to me if I wish (a tissue form is required). | ☐ | ☐ | ☐ |
| **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. | ☐ | ☐ | ☐ |
| **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. | ☐ | ☐ | ☐ |
| **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. | ☐ | ☐ | ☐ |

**Patient/Guardian Signature:**

Date: