SOUTHERN CROSS
CENTRAL LAKES HOSPITAL
QUEENSTOWN

Agreement To Treatment
(Consent form)

Important: Please take this completed form with you to the hospital where you will have your procedure.

You and your doctors will complete this form together as part of the process of informed consent.

Do you need an interpreter? ☐ Yes   Which language? ______________________

Patient details

Surname (family name): ______________________ NHI: ______________________

First name (s): ______________________ Date of birth: ____ / ____ / ____ (dd / mm / yyyy)

Name of procedure

I, ______________________ (or my representative ______________________)

agree to the following procedure/operation/treatment:

____

____

____

Is a side of the body involved?   Left / Right / Both *(Please circle)*

The reasons for this procedure, the alternatives, and the possible risks have been discussed with me.
These include (but are not limited to):

____

____

____

Blood and blood products *(fill out only if needed)*

Blood or blood product transfusion may be needed during or after the procedure. The reasons for transfusion, the alternatives, and the possible risks have been discussed with me. I have been provided with the **NZ Blood Service Fresh Blood Components** leaflet.

☐ I agree to receive blood and blood products   ☐ I do not agree to the administration of blood/ blood products

Please also refer to 'Limited consent for blood transfusion therapy (adult)' form

Allograft (donor) bone or other tissue implants *(fill out only if needed)*

The reasons for tissue implants, the alternatives, and the possible risks have been discussed with me.

☐ I agree to receive allograft bone or tissue implants   ☐ I do not agree to receive bone or tissue implants

Return of my own tissue, body parts, or explanted devices *(fill out only if needed)*

☐ I request that any tissue, body part, or explanted device that is not required for testing is returned to me.

Please also refer 'release of surgically removed tissue/body parts and explanted devices' form

Patient or representative declaration

I agree that:

- I have had a good explanation about my procedure from the doctor who has signed below. I have had a chance to ask questions about the procedure. I can ask for more information at any time, and participate in ongoing decisions about my treatment.
- Southern Cross Central Lakes Hospital is a significant distance from a secondary or tertiary hospital. Should complications arise that necessitate my transfer, there may be delays to a transfer due to weather, distance, or other factors which could result in deterioration of my condition. I have discussed this risk and the option of surgery at Southern Cross Central Lakes Hospital or another facility and agree to have surgery at Southern Cross Central Lakes Hospital.
- If a caregiver is accidentally exposed to my blood or body fluids, a sample of my blood may be tested for transmissible diseases. I will be told the results if I request them, or where further medical referral is required.
- I give permission to Southern Cross Central Lakes Hopital, or any health professional involved in my care or any funder, to access my health information that is relevant to my treatment, including pre-admission and after discharge. See our privacy statement for further details.

Patient/Guardian signature: ______________________ Date: ____ / ____ / ____ (dd / mm / yyyy)

If not patient, state relationship to patient: ______________________

(Where applicable please attach evidence of enduring power of attorney)

Admitting doctor declaration

I have adequately informed the patient about their procedure (including the benefits, risks, expected outcomes, and, alternative options, including not having the procedure).

I have given the patient the opportunity to raise concerns and ask questions.

Admitting doctor's name: ______________________ Surgeon / Physician *(Please circle)*

Admitting doctor's signature: ______________________ Date: ____ / ____ / ____ (dd / mm / yyyy)

SOUTHERN CROSS
CENTRAL LAKES HOSPITAL
QUEENSTOWN

Hospital Administration only
(Patient label)

Agreement To Treatment

(Consent form)

Important: Please take this completed form with you to the hospital where you will have your procedure.

This section is completed with you by the anaesthetist usually on the day of surgery

Proposed anaesthesia: General ☐ Local ☐ Regional ☐ Spinal/epidural ☐ Sedation ☐ *(Please tick)*

Other: ___

Risk discussion

Sore throat ☐ Nausea/vomiting ☐ Dental damage ☐ Allergic reaction ☐ Itch ☐ Blood clots ☐

Block failure ☐ Nerve damage ☐ Headache ☐ Hypotension ☐ Rare serious events ☐ Pain ☐ Bleeding ☐

All of the above discussed ☐

Pain relief plan

Oral ☐ Intravenous ☐ PCA ☐ Epidural ☐ Spinal ☐ Wound catheter ☐ PR ☐ Other ☐

Discussion notes: ___

Anaesthetist declaration

I have discussed the proposed anaesthetic plan and possible alternatives with the:

Patient ☐ Parent/Guardian ☐ Spouse/Partner ☐ Next-of-Kin ☐ EPOA ☐

Anaesthetist name: ___ **Date:** ___ / ___ / ___ (dd / mm / yyyy)

Anaesthetist signature: ___

Patient or representative declaration

I, ___ *(Patient's/Guardian's full name)* agree to anaesthesia/sedation being given to

myself / my child *(Please circle)* ___ *(Name of patient, if patient not signing form)*

I agree that:

- I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and understand I may seek more information at any time.
- I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.
- I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had general anaesthesia.

Patient/Guardian signature: ___ **Date:** ___ / ___ / ___ (dd / mm / yyyy)

If not patient, state relationship to patient: ___

(Where applicable, please attach evidence of enduring power of attorney)