Government of **Western Australia**
Department of **Health**

# Form A: Patient consent to treatment – adult or mature minor

| Affix hospital identification here | Affix patient identification label here |
|---|---|
| **Patient consent to treatment**<br>If using this form, the patient has been deemed to have capacity to make this decision. **If not, do not use this form**. Refer to the 'WA Hierarchy of Treatment Decision-Makers'. Follow the 'WA clinician consent to treatment flowchart' and use Form C. | |

## Treatment/procedure/investigation

List the treatment(s)/procedure(s)/investigation(s) to be performed (referred to as "Treatment" in this form), noting correct location of the Treatment (no abbreviations):

.....

.....

.....

This Treatment requires:

☐ Local anaesthesia ☐ Insertion of implantable medical device ☐ General and/or regional anaesthesia

An anaesthetist will explain the risks of general or regional anaesthesia.

## Provision of written information

The following information sheet/s have been provided:

☐ Procedure Specific Information Sheet (PSIS) ☐ No PSIS available ☐ Other (please specify):

.....

## Risks and complications

Risks and benefits discussed with the patient include:

.....

.....

.....

.....

If blood and blood product transfusion/infusions are anticipated, refer to the 'Consent to Blood and Blood Products' form (Form E). If consent for blood and blood products is declined, please refer to your 'Refusal of Blood Products' form.

## Signature of doctor/health practitioner who has determined consent has been obtained

Risks and benefits of the treatment have been discussed with the patient and relevant consent discussions are documented within this form and within the patient's medical record should additional space be required.

Doctor/Health practitioner's full name (print) .....

Position/title .....

Doctor/Health practitioner's signature ..... Date ..... Time .....

## Patient's declaration

1. I have been given written information about the Treatment (if available).
2. I understand that the doctor/health practitioner who discusses the Treatment with me for the purpose of consent may be different to the doctor/health practitioner who performs the Treatment.
3. I have been informed of and understand the risks that are specific to me, the benefits, the alternatives (including if I choose not to have the Treatment), and the likely outcomes.
4. I have been given the opportunity to ask questions about this Treatment and my specific queries and concerns have been answered.
5. I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
6. **I consent to a blood product transfusion** ☐ YES ☐ NO (please tick). The risks, benefits and alternative treatments have been explained to me and I have received written information.
7. If a staff member is exposed to my blood, I consent to my blood being collected and tested for infectious diseases. I will be informed if this occurs and will be given results of the tests.
8. I consent to an examination by a health practitioner student, supervised by a doctor/health practitioner while I am anaesthetised ☐ YES ☐ NO ☐ N/A (please tick).
9. I consent to de-identified medical photography and video for the purposes of medical research and training.
10. I understand that I have the right to change my mind and can withdraw my consent to Treatment at any time before the Treatment is performed, including after I have signed this form. I understand that I must inform my doctor/health practitioner if this occurs.
11. I consent to undergo the Treatment as documented on this form.

Patient's full name (print) .....

Patient's signature ..... Date ..... Time .....

## Interpreter's declaration (if applicable)

Specific language services required .....

I declare that I have interpreted the dialogue between the patient and doctor/health practitioner about the Treatment to the best of my ability and have advised the doctor/health practitioner of any concerns about my interpreting of this dialogue.

Interpreter's full name (print) .....

Agency name ..... NAATI number .....

Interpreter's signature ..... Date ..... Time .....

Interpreting took place: ☐ in person or ☐ via phone/videoconference

## Review of consent (if applicable)

I confirm that the patient's consent, and clinical condition have been reviewed and the Treatment is still appropriate to be undertaken.

Doctor/Health practitioner's full name (print) .....

Position/title .....

Doctor/Health practitioner's signature ..... Date ..... Time .....

I confirm that my request for and consent to the Treatment above remains current and I am satisfied that I have enough information to make this decision.

Patient's signature ..... Date ..... Time .....

Produced by Patient Safety and Clinical Quality


PSQ-014120 APR'23