Waitematā District Health Board
Best Care for Everyone

Waitematā DHB Wide

[PLACE PATIENT LABEL HERE]			
First Name: ____________		**Gender:** ________	
Surname: ____________		**Ph:** ____________	
Address: ____________			
Date of Birth: ________		**NHI#:** ________	
Ward/Clinic: ________		**Consultant:** ________	

Agreement to Treatment / Consent

Do you need an interpreter? Yes ☐ No ☐ Language: ____________________________

Surgery and other procedures

This form must be completed by the patient; or on behalf of the patient by their parent, guardian, welfare guardian or with enduring power of attorney* See footnote on page 2

I____ (your name) agree to the following procedure:

____

____

Answer this question if relevant: The procedure is on the **Right side /Left side** (circle one) of my body.

The risks of the procedure that have been discussed with me are: ________________________________

____

____

The reasons for the procedure, its benefits, other possible treatments, and risks have been explained to

me by: **Clinician name:** ___________________________ **Clinician signature:** _______________________

Clinician designation: ____

I agree that: *[Cross out anything you don't agree with]*

- I have had an opportunity to ask questions and I have received all the information I need.
- In an emergency, my medical team will decide if other procedures are needed to save my life or prevent harm.
- If I am receiving care in a teaching organisation, healthcare students may be present to watch and learn. I understand they will be appropriately supervised and I can ask them to leave at any time during the procedure.
- My care will be delivered by a team which may include doctors, nurses, midwives, allied health, scientific, and technical clinicians, or clinicians in training.
- If possible, I will be introduced to the clinical staff carrying out my procedure.
- If any clinicians carrying out my procedure are in training, they will be appropriately supervised by a senior clinician.

Blood accidents

- If a healthcare worker is accidentally exposed to my blood or other body fluids, I agree a sample of my blood can be taken and tested for transmissible diseases such as Hepatitis and HIV.
- I understand I will be told if this happens and all test results will be discussed with me and if required, I will be offered treatment.

Return of Body Parts

- If any body part or tissue is removed during this procedure, I want this returned to me, if possible: **Yes / No** (*circle one*)

Patient /Guardian/Attorney signature: __________________________________ **Date:** ____/____/_____

Interpreter name:_________________________ **Interpreter signature:**_____________________________

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[PLACE PATIENT LABEL HERE]

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Surname: ______________________ **Ph:** ________________
Address: ____
Date of Birth: __________ **NHI#:** ____________
Ward/Clinic: __________ **Consultant:** ____________

Agreement to Treatment / Consent

Anaesthesia

I understand Anaesthestic is medicine that will numb parts of my body or make me unconscious or sleepy, for the procedure on page 1.

I agree to the following Anaesthetic being used: ____

____

With my medical history and condition, the possible benefits and risks of the Anaesthetic have been explained to me. The risks are: ____

____

____

____

I have been told NOT to drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcohol or make important decisions for 24 hours after having a general anaesthetic or sedation.

Patient/Guardian/Attorney signature: ____________________________ **Date:** _____/____/_______

Anaesthetist name: ________________________ **Anaesthetist signature:** ____________________

Date: ____/____/______

Interpreter name: __________________________ **Interpreter signature:** ____________________

Receiving blood and blood products

I agree

- I have been told that I may need blood, or transfusions of blood products.
- I have been told the possible risks, benefits and alternatives to blood transfusion.
- I understand the risks of refusing blood transfusion.
- I have had the opportunity to ask questions and discuss this with the clinician named below.

Tick the statement that is correct for you

☐ **I agree** to receive blood or blood products if the clinicians looking after me think they are necessary. I understand I may need repeated transfusions. **Or**

☐ **I do not agree** to receive blood or blood products for any reason and I understand the risks of this decision.

Patient/Guardian/ Attorney signature: ____________________________ **Date:** _____/_____/_____

Clinician name: ____________________________ **Clinician signature:** ____________________

Clinician designation: ____ **Date:** _____/_____/_____

Interpreter name: __________________________ **Interpreter signature:** ____________________

*If a patient has been determined to lack capacity to give consent, seek guidance of Right 7 (4) with legal counsel and complete a Treatment / Procedure(s) Without Consent Form