Acupuncture Consent

Informed consent. The practitioner fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

PRACTITIONER NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

TECHNIQUE

SESSIONS PLANNED

Fine, sterile, single-use needles are placed in the skin for a short time. Cupping, if used, can leave circular marks for several days.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Minor bleeding or bruising
- Drowsiness or feeling faint during treatment
- Temporary worsening of symptoms
- Rarely, infection or puncture of a lung with chest points

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Physiotherapy or exercise
- Medicines prescribed by your doctor

Your health

Do you take blood thinners or have a bleeding disorder?

○ No ○ Yes

Are you pregnant?

○ No ○ Yes

Do you have a pacemaker (for electro-acupuncture)?

○ No ○ Yes

Are you afraid of needles or prone to fainting?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The practitioner has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Practitioner

SIGNATURE

PRINTED NAME

DATE