Surgery Consent Form

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

Clinic and clinician

HOSPITAL OR CLINIC

SURGEON NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

NAME OF OPERATION

PLANNED DATE

SIDE / SITE

ANAESTHESIA PLANNED

EXPECTED STAY (DAYS)

The surgeon has explained why the operation is advised, what will be done, how long recovery takes, and what happens if it is not done. A separate anaesthesia consent is taken by the anaesthetist.

Risks

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

- Bleeding, which may need a transfusion
- Wound infection or delayed healing
- Blood clots in the legs or lungs
- Injury to nearby organs, nerves or vessels
- The need for a further or bigger operation
- Rarely, serious complications including death

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Medicines or other non-surgical treatment, where suitable
- Watchful waiting
- A different surgical approach (open, laparoscopic, robotic)

Your health

Do you take blood thinners (aspirin, clopidogrel, warfarin)?

○ No ○ Yes

Have you had problems with a previous operation or anaesthetic?

○ No ○ Yes

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

☐ I agree that tissue removed may be examined in a laboratory and then disposed of as per biomedical waste rules.

☐ I agree to photographs or video of the procedure for my medical record and anonymised teaching.

Initials

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The surgeon 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

Surgeon

SIGNATURE

PRINTED NAME

DATE

Witness 1

SIGNATURE

PRINTED NAME

DATE