

HSS TRUST _____
Hospital Unit _____

GP PRACTICE or other _____
Primary Care Provider _____

FORM 1 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name
First names
Date of Birth
 Male Female H+C No. (or other identifier)
Special requirements (language or other)
.....

Statement of healthcare professional

Responsible healthcare professional Job Title.....
Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*
.....
.....
I have explained the procedure. In particular, I have explained:
.....
.....
The intended benefits
.....
.....
Serious or frequently occurring risks
.....
.....
Possible additional procedures which may become necessary during the procedure.
 Blood transfusion other procedure (please specify).....
This procedure will involve: general and/or regional anaesthesia local anaesthesia sedation
I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.
 The following leaflet/tape has been provided.....
Signed Date
Name (Print) Job Title
Contact details *(if patient wishes to discuss options later)*

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.
Signed Date
Name (Print)

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....
.....

***I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. ** You may remove this sentence without affecting your care.*

SignatureDate

Name (Print)

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

SignatureDate

Name (Print).....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

SignatureDate

Name (Print)Job Title

Important notes: (tick if applicable)

See also advance directive/living will (eg Jehovah's Witness form)

Person has withdrawn consentDate.....

(ask person to sign/date here)