



IMPORTANT: Please send this completed form to the Hospital where you will have your procedure/surgery.

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: ____/____/____ Diagnosis: _____
d m y

Procedure/operation/treatment description: _____

Operative side of body: Left / Right / Bilateral / Not applicable *(please circle)*

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Admission details

Admission date: ____/____/____ Admission time: _____ Procedure/Surgery date: ____/____/____
d m y (If different to admission date) d m y

Day stay unit Day inpatient Overnight inpatient Anticipated length of stay _____ hours / days / nights

Admitting doctor's instructions: _____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner
(please circle)

Admitting doctor's signature: _____ **Date:** ____/____/____
d m y

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN

I, _____ agree to have the procedure/operation/treatment described
(Patient's/Guardian's full name)

above performed on myself / my child _____ at _____
(please circle) (name of patient, if patient not signing form) (Hospital where you will be having your procedure/surgery)

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment, and the possibility and nature of further related treatment including a return to theatre, should any complications arise.

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I agree to blood or blood products that may be required.

I agree to anaesthesia/sedation.

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk e.g. Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to Southern Cross Hospital or any health professional involved in my care for this admission to Hospital, to access health information about me that is relevant to my current treatment, which may be held by Southern Cross, other health professionals or other health organisations.

Patient/Guardian signature: _____ **Date:** ____/____/____
d m y

If not patient, state relationship to patient: _____
(where applicable please provide evidence of enduring power of attorney).

Hospital Administration only
(Please insert patient label)

IMPORTANT: Please complete this form during your consultation with the anaesthetist.

AGREEMENT TO ANAESTHESIA

THIS SECTION IS COMPLETED BY THE ANAESTHETIST

Sedation: Yes No **Anaesthesia:** Yes No **Proposed anaesthesia:** general / local / regional / spinal / epidural
(please circle)

Details: _____
(please state)

Anaesthetist's name: _____

Anaesthetist's signature: _____ **Date:** ___ / ___ / ___
d m y

Anaesthetist's instructions: _____

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)
myself / my child _____
(please circle) (name of patient if patient not signing form)

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had the anaesthesia.

Patient/Guardian signature: _____ **Date:** ___ / ___ / ___
d m y

If not patient, state relationship to patient: _____
(where applicable please provide evidence of enduring power of attorney).