CAMPSIE DAY SURGERY

CONSENT FORM

Consent to medical or surgical treatment

Attach Patient Label

Part A: Provision of Information to Patient *(To be completed by Medical Practitioner)*

I, Dr. ..... have informed .....

(Name of medical practitioner) *(Name of patient/parent/guardian)*

Of the nature, likely results, and material risks of the recommended operation/procedure and/or treatment.
The agreed operation/procedure and treatment that the patient is to undergo is:

.....

(Name of operation/procedure and/or treatment)

To be held on ..... / ..... / ..... at ..... : ..... am/pm

Signature of Medical Practitioner: ..... **Date**: ..... / ..... / .....

Part B: Patient Consent *(To be completed by Patient/Guardian)*

The doctor whose name appears in part A above and I have discussed my present condition and the various and alternative ways in which it might be treated. The doctor has told me that:

- The administration of an anaesthetic and medicines may be needed in association with this operation/ procedure and/or treatment and these carry some risks.
- Additional procedure or treatment may be needed if the doctor finds something unexpected and an appropriate charge may be applied. I agree to these additional procedures and/or treatments being carried out for additional costs if required as long as they are related to the primary procedure set out in Part A.
- Even though the operation/procedure and/or treatment are carried out with all due professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carry some risks and that complications may occur.
- I have been given the opportunity to ask questions of the doctor named above and understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risk.
- I have been advised of the material risks associated with this operation/procedure and/or treatment.
- I have had the opportunity to ask questions about the operation/procedure and/or treatment and I am satisfied with the answers and information I have received.
- I understand that I may withdraw my consent at any time prior to the operation/procedure and/or treatment.
- I request, understand and consent to the operation/procedure and/or treatment as outlined above in Part A.

.....

(Name of operation/procedure and/or treatment)

Signature of Patient / Guardian: ..... **Date**: ..... / ..... / .....

Part C: Discharge Planning for Day Surgery Patients

- I understand that I will be discharged on the same day as my anesthetic/sedation and procedure/surgery.
- I will not drive a motor vehicle, operate machinery or other potentially dangerous appliances, drink alcohol, or make critical decisions for 24 hours.

Do you have someone responsible to take you home after the procedure / surgery? Yes ☐ No ☐

Signature of Patient: ..... **Date**: ..... / ..... / .....

Theatre nurse to check off: Patient consent completed □ Correct patient & information details □

Nurse to sign after checking: Name ..... **Signature**: .....

CAMPSIE DAY SURGERY

PATIENT INFORMATION FORM

- ***To be completed by the patient***
- ***Please print clearly and ensure you complete all questions***

Attach Patient Label

PATIENT DETAILS

For statistical data please circle: Single / Married / Divorced / Widowed Title: Mr. / Miss / Mrs. / Ms.

First Name: …… Last Name: …….. DOB: …… / …… /……

Address: …… Suburb: …….. State: …… Postcode: ……

Mobile No: …… Work No: …… Home No: ……

HEALTH CARE FUND DETAILS

Medicare Card No: ☐☐☐☐ ☐☐☐☐☐ ☐ IRN: ☐ Valid to ☐☐/☐☐☐☐

Veterans Card Number: …… ☐ Gold ☐ White

Aged Pension Card (Aged 65 & over): ……

Do you have Private Health Fund [Hospital Cover]? ☐ Yes ☐ No

Name of Private Health Fund: ……

Membership No: ……

NEXT OF KIN OR CONTACT PERSON

First Name: …… Last Name: ……

Mobile: …… Home: …… Relationship: ……

DOCTOR OR GP DETAILS

Referring GP Name: …… PH: ……

ADMISSION HISTORY

Have you had procedure in Campsie Day Surgery before? Yes ☐ No ☐

If yes, Date: …… / …… /……

Procedure: ……

ETHNIC BACKGROUND (*Campsie Day Surgery would like to ensure that a patient's ethnic and religious background is respected and met. Please complete the following).*

What is your Country of Birth? ……

Religion: ……

What language do you speak at home / every day? ……

Are you of Indigenous Decent? Aboriginal: Yes ☐ No ☐ Torres Strait Islander: Yes ☐ No ☐

Thank you for completing this form.
All information given is private and confidential and will be treated under the Privacy Act of NSW

Patient to Sign: …… **Date:** …… / …… /……

CAMPSIE DAY SURGERY

PATIENT MEDICAL HISTORY FORM

Date of Procedure: ..... / ..... /..... **Time:** ..... : .....

Procedure: ☐ Gastroscopy ☐ Colonoscopy

☐ Gastroscopy & Colonoscopy ☐ Other .....

ALLERGIES: ☐ Medication ☐ Egg ☐ Peanut ☐ Soy ☐ Other

Please list allergies/ adverse reaction: .....

.....

Attach Patient Label

MEDICAL HISTORY

☐ Heart Problem	☐ Chest Pain	☐ Arthritis
☐ Blood Pressure [High / Low]	☐ Diabetes	☐ Sleep Apnoea
☐ Pacemaker / Implants	☐ Hepatitis	☐ Smoker [Past / Present]
☐ Stroke / Blood Clots	☐ Asthma / Lung Disease	☐ AIDS / HIV Positive
☐ Thyroid Disorders	☐ Recent Respiratory Infection	☐ Alcohol
☐ Bleeding / Blood Disorder	☐ Liver Problem	☐ Pregnant / Breast Feeding
☐ Kidney / Bladder Disease	☐ Epilepsy / Convulsion / Fits	☐ Others

If you answered yes to any of the above, please provide more information: .....

.....

MEDICATIONS

Please list current medications:

Medication - Dose & Frequency	Medication - Dose & Frequency	Medication - Dose & Frequency

- Are you currently taking **Warfarin/Plavix blood thinning medication** or **Arthritis tablets/Steroids**? ☐ Yes ☐ No

  If Yes, have you been instructed to cease this medication? ☐ Yes ☐ No
- Previous surgery? ☐ Yes ☐ No

  If yes, please provide details: .....
- Previous anaesthetics? ☐ Yes ☐ No

  If yes, were there any complications: ☐ Yes ☐ No
- Do you have an advance care or treatment plan? ☐ Yes ☐ No If yes, where is it? .....

ACKNOWLEDGEMENT OF PATIENT MEDICAL HISTORY

The information in this form that I have given, is true to the best of my knowledge.
I understand that I will be unfit to drive until the day after the procedure and will make alternative travel arrangements
I also give may consent to the Campsie Day Surgery to release all information concerning may condition, treatment and personal details to my GP, my Medical Insurer and any medical specialist that my Gastroenterologist refers me to for further treatment or medical opinion in accordance with the Privacy act 2002, HRIPA ACT.

Name of Patient: ..... **Signature:** ..... **Date:** ..... / ..... / .....

Reviewed by Name: ..... **Signature:** .....