Queensland Government

Generic Consent – Adult

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

A. Does the patient have capacity?

☐ Yes ➔ ***GO TO** section B* ☐ No ➔ ***COMPLETE** section A*

i. a) Is the patient aged under 18 years?
☐ Yes (document parent / guardian name below)
☐ No ➔ ***GO TO** ii*

You must adhere to the Advance Health Directive (AHD) or the consent obtained from a substitute decision-maker.

ii. a) Does the patient have an AHD that is applicable to the procedure, treatment or investigation?
☐ Yes ☐ No ➔ ***GO TO** iii*

b) If *yes*, has the AHD been sighted and a copy in the medical record?
☐ Yes ☐ No ➔ ***GO TO** iii*

iii. a) Substitute decision-maker (select one only):
☐ Attorney(s) for health matters under an Enduring Power of Attorney or AHD
☐ Tribunal-appointed guardian
☐ Statutory Health Attorney
☐ If none of these, the Office of the Public Guardian must provide consent (ph: 1300 653 187)

Name of substitute decision-maker(s) or parent / guardian:

Signature of substitute decision-maker(s) or parent / guardian:

Relationship to the patient (e.g. substitute decision-maker or parent / guardian)

Date: Phone number:

B. Does the patient need Interpreter / cultural services?

i. a) Is a language interpretation service required?
☐ Yes ☐ No ➔ ***GO TO** ii*

b) If *yes*, is a qualified Interpreter present?
☐ Yes (complete section K) ☐ No ☐ N/A

ii. a) Is a cultural support person required?
☐ Yes ☐ No ➔ ***GO TO** section C*

b) If *yes*, is a cultural support person present?
☐ Yes ☐ No ☐ N/A

C. Condition and treatment

The Doctor / Clinician has explained that I have the following condition *(Doctor / Clinician to document in patient's words)*:

This condition requires a procedure *(Doctor / Clinician to document, include site and / or side where relevant to the procedure)*:

The following will be performed *(provide brief description)*:

D. Risks and complications of this procedure

There are risks and complications with this procedure. They include but are not limited to the following.

Common risks and complications include:

- **infections** can occur, requiring antibiotics and further treatment;
- **bleeding** could occur and may require a return to the operating room;
- bleeding is more common if you have been taking **blood thinning drugs** such as warfarin, aspirin, clopidogrel (Plavix, Iscover, Coplavix), prasugrel (Effient), dipyridamole (Persantin or Asasantin), ticagrelor (Brilinta), ticlopidine (Tilodene), apixaban (Eliquis), dabigatran (Pradaxa), rivaroxaban (Xarelto) or complementary / alternative medicines such as fish oil;
- small areas of the **lung can collapse**, increasing the risk of **chest infection**. This may need antibiotics and physiotherapy;
- increased risk of wound infection, chest infection, heart and lung complications, and blood clot in the leg or lungs for **people who are obese**.

Uncommon risks and complications include:

- **heart attack or stroke** could occur due to the strain on the heart;
- **blood clot** in the leg causing pain and swelling. In rare cases, part of the clot may break off and go to the lungs.

Rare risks and complications include:

- **death** as a result of this procedure is rare.

E. Specific risks for you in having this procedure

(Doctor / Clinician to document in space provided. Continue in Medical Record if necessary)

F. Risks of not having this procedure

(Doctor / Clinician to document in space provided. Continue in Medical Record if necessary)

G. Alternative procedure, treatment or investigation options

(Doctor / Clinician to document in space provided. Continue in Medical Record if necessary)

DO NOT WRITE IN THIS BINDING MARGIN

GENERIC CONSENT – ADULT

v7.00 - 08/2016

SW9436

Queensland Government

Generic Consent – Adult

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

H. Anaesthetic

This procedure may require an anaesthetic *(doctor / clinician to document type of anaesthetic discussed)*

I. Anticoagulant / Antiplatelet checklist

Information to discuss with your doctor about blood thinning drugs:

Aspirin ☐ Yes ☐ No

Antiplatelet agents ☐ **YES** ☐ No

Clopidogrel, Prasugrel, Ticagrelor, Dipyridamole, Other.

If the procedure is elective, can the antiplatelet be withheld and the patient maintained on aspirin alone for 7 days prior? ☐ Yes ☐ **NO**

Date Authorising doctor / clinician ordered antiplatelet ceased / to be ceased:

Warfarin / Dabigatran / Rivaroxaban / Apixaban / Heparins / Other new anticoagulants ☐ **YES** ☐ No

If elective procedure, can all anticoagulation be ceased before the procedure? ☐ Yes ☐ No

Where there has been changes (i.e. ceased, withheld) to the above drugs, is there a management plan documented in the patient's medical record? ☐ Yes ☐ No

J. Patient / Substitute decision-maker consent

I acknowledge the doctor / clinician has explained:

- my / the patient's medical condition and the proposed procedure / treatment / investigation may require and include additional treatment if the doctor / clinician finds something unexpected. I understand the risks and benefits, including the risks specific to me;
- my / the patient's requirement for anaesthetic for this procedure / treatment / investigation - I understand the risks associated with anaesthetic, including the risks specific to me (see *Anaesthetic* information sheet);
- my / the patient has alternative procedure / treatment / investigation options;
- my / the patient's prognosis, and the risks of not having the procedure / treatment / investigation;
- no guarantee has been made that the procedure / treatment / investigation will improve my / the patient's condition even though it has been carried out with due professional care;
- my / the patient's procedure / treatment / investigation may include a blood transfusion;
- my / the patient's tissues / blood may be removed and be used for diagnosis / management of my condition, stored and disposed of sensitively by the hospital;
- if an immediate life-threatening event happens during my / the patient's procedure / treatment / investigation, I / the patient will be treated based on my discussions with the doctor / clinician or *Acute Resuscitation Plan*;
- a doctor / clinician other than the consultant / specialist may conduct the procedure / treatment / investigation. I understand this could be a doctor undergoing further training who will be supervised according to relevant professional body guidelines;
- I / the patient was able to ask questions and raise concerns with the doctor / clinician about my / the patient's condition, the proposed procedure / treatment and its risks, and my / the patient's treatment options. My questions and concerns have been discussed and answered to my satisfaction;
- I / the patient understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with a doctor / clinician;
- I / the patient understand image(s) or video footage may be recorded as part of and during my procedure and that these image(s) or video(s) will assist the doctor / clinician to provide appropriate treatment.

On the basis of the above statements,
I consent to having this procedure.

Name of patient:

Signature: Date:

I consent to:

Name of patient having procedure:

Name of substitute decision-maker:

Signature: Date:

I have received the following information sheet(s):

☐ *'About your Anaesthetic'*

☐ Procedure:

Name of procedure:

☐ *'Blood and Blood Products Transfusion'*

K. Interpreter's statement

I have:

☐ Provided a sight translation

☐ Translated as per clinician explanation in:

Patient's language:

of this consent form and assisted in the provision of any verbal and written information given to the patient / substitute decision-maker by the doctor / clinician.

Name of patient:

Language of patient:

Name of Interpreter service:

Name of Interpreter:

Interpreter's signature: Date:

L. Doctor / Clinician / Delegate statement

Information for doctor / clinician / delegate:

The information contained within this form is not, and is not intended to be, a substitute for direct communication between the doctor / clinician / delegate and the patient / substitute decision-maker regarding the medical procedure, treatment or investigation described in this form. I have explained to the patient all the content in this patient consent form and I am of the opinion that the patient / substitute decision-maker has understood the information.

Name of doctor / clinician / delegate:

Designation:

Signature: Date:

DO NOT WRITE IN THIS BINDING MARGIN

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