AESTHETIC DAY SURGERY

A.C.N. 147 561 975 A.B.N. 29 834 680 521

14 Kensington Street
KOGARAH 2217

TEL: 9553 9905 FAX: 9553 9924

Patient Label

To be completed by the ADMITTING DOCTOR

PLEASE ADMIT:

Patient Surname:	Given Names
Address:	
Date of Birth:	Sex:

Provisional Diagnosis:
Relevant History and Co-Morbidities:
Current Medications:
Adverse Drug Reaction/Allergies:

Proposed Operation/Treatment:
Date of Operation/Treatment:
Item Numbers:
Specific Pre-Operative Instructions:

CERTIFICATE BY ADMITTING DOCTOR:

I certify that I have provided an explanation to the above patient/legal guardian as to the effect of the operation/treatment, and that in my opinion the patient/legal guardian has understood the explanation.

NAME: SIGNATURE: DATE:

DOCTOR'S REFERRAL SHEET 001B

AESTHETIC DAY SURGERY

A.C.N. 147 561 975 A.B.N. 29 834 680 521

14 Kensington Street
KOGARAH 2217

TEL: 9553 9905 FAX: 9553 9924

Patient Label

PART A to be completed by the treating DOCTOR

I have discussed with my patient / patient's guardian / person responsible as named below:

- the patient's present condition,
- alternative treatments available, and
- the benefits and risks of the proposed operation / procedure / treatment.

The proposed operation/procedure/treatment is [PRINT]: .....

.....

....

Medical Officer's Name Signature

PART B to be completed by the PATIENT / Guardian / Person Responsible

I consent to the above operation / procedure / treatment to be performed on:

Name of Patient: .....

- I also consent to the administration of anaesthetics, medicines and other forms of treatment normally associated with this operation / procedure / treatment.
- I understand that other unexpected operations / procedures / treatments may be necessary and I request that these be carried out if required.
- Although this operation / procedure / treatment is carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.
- I also understand that complications may occur with any operation / procedure / treatment, and I accept the possible risks associated with this operation / procedure / treatment as discussed by the doctor named above.
- I have had the opportunity to ask questions about the above operation / procedure / treatment, and I am satisfied with the information I have received.
- I consent to blood being taken for testing for HIV and other diseases in the event of accidental staff injury involving contact with the patient's blood. I understand that pre-test counselling will be provided if blood taking for this purpose is recommended.
- I do not consent to: .....

....

Name of Patient / Guardian / Person Responsible Signature of Patient / Guardian / Responsible Person

....

Relationship of Guardian / Person Responsible to patient Date

....

Name of Witness to signature Signature of Witness

.....

Name and signature of Interpreter (if required)

CONSENT FORM

001C