Request for Treatment / Procedure(s)

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

CONSENT - REQUEST FOR TREATMENT/PROCEDURE(S)

I, _____

_____

(patient, parent, guardian, personal care and welfare attorney) request that the following procedure / treatment be performed on me / my child / person lacking capacity to give consent.

(name of patient if different from above name) _____

Attach patient label here

_____

Description of treatment/procedure(s)

I understand the nature, benefits and risks of the above treatment and / or procedure(s). I have had explained to me the alternative treatment and / or procedure(s) available, including not having any treatment. I have had the opportunity to ask my questions about the above treatment and / or procedure(s). I am aware that I may ask for more information at any time and that my health information may be used for quality audit purposes.

I agree that if during the treatment/procedure(s) there is an unexpected finding or event additional procedures deemed to be essential might be carried out.

I agree to my blood being taken for testing in the event of a staff member being exposed to my blood or body fluid.

	YES	NO	N/A
I understand the nature, benefits and risks of receiving blood components / blood products and agree to receiving these if it is clinically necessary and in my own best interests.			
I understand and agree that written, electronic, radiographic, video, sound and photographic records may be made and stored, and may be referred to at a later date for teaching purposes and /or for Ethics Committee approved research.			
I understand that this treatment is being carried out in a teaching hospital and agree to observation of and participation in my treatment and / or procedure(s) by students under appropriate supervision.			
I understand that following this treatment / procedure(s), I may be sedated and should not drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcohol or make important legal or financial decisions for at least 18 hours afterwards.			
I understand that tissue removed during the treatment/procedure(s) may be submitted for pathological examination, kept and referred to at a later date for clinical purposes, audit, teaching and for Ethics Committee approved research. I understand that the tissue may be returned to me if I wish (a Tissue Return Form (CCDHB) or a Body Part Chain of Custody Form (HVDHB) is required).			

Signature of patient / parent / guardian / personal care and welfare attorney _____ Date / /

Name of health professional _____ Date / /

Signature _____ Designation _____

The treatment / procedure I intend to perform on / / is correctly described above.

If person performing treatment / procedure(s) is different from person signing above:

Name: _____

Signature _____ Designation _____ Date / /

Please turn over to add supporting relevant information.

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Supporting relevant Information:

Add additional pages as required