memo

Cabrini

To: All Medical Staff

From: Prof Matt Sabin, Group Director Medical Services and Clinical Governance

Date: Monday 19 June 2023

Subject: Cabrini Consent Forms Update 1

Dear Medical Staff,

We have reviewed our patient consent forms to align them with legislative requirements, best practices and recommendations from ACHS accreditation.

A multi-disciplinary Working Group was convened to redesign the consent forms.

After extensive consultation, including with the Medical Staff Executive, two new forms have been developed:

1. '**Consent to Procedure or Surgical Treatment**' (MR002DS) – for all invasive or high-risk procedures and surgeries (digital version attached).

2. '**Consent to Medical Treatment and/or Blood Product Administration**' (MR002DM) – for invasive or high-risk medical treatments, such as chemotherapy, blood transfusions, or iron infusions (digital version attached).

Key changes include:

- Signatures are now required from the treating Medical Practitioner and the patient before treatment commencement. These signatures are not required to be completed on the same date or time.

- Treating Medical Practitioner (rather than the patient) must describe the treatment and any expected secondary treatments (e.g., +/- open).

- Specific section added to document the treatment or procedure risks. You can reference other documents here, e.g. "See letter given to the patient on 1 Jan 2023 in rooms" or "See information sheet given to the patient on colonoscopies".

- Removal of consent to the Anaesthesia or Sedation section, which should be documented in the Anaesthetic Record, or the relevant risks included in Part A if an Anaesthetic Record is not utilised.

- Consent to blood and blood products (Part C) is optional on both forms and only needs completion if anticipated.

- The 'Consent to Medical Treatment and Blood Product Administration' form can be used solely for blood product consent.

- Either of the two consent forms will be accepted as valid documentation of consent, i.e. completing the 'Consent to Medical Treatment and Blood Product Administration' form for a surgical procedure will be accepted, and vice versa.

- Forms will be available in digital PDF format. These can be pre-populated with standard procedures and risks, then printed and signed. If printing your forms, please ensure you use 80-120gsm paper to comply with health record standards. Further work is being done to support digital signatures and form submissions in the future.

These new consent forms will be rolled out across Cabrini Health **from 3 July 2023**.

Update 2 will have all the information regarding the ordering of forms, completion/submission processes and contact details to provide your feedback.

We appreciate your understanding as we implement these significant changes to improve patient care at Cabrini.

Kind regards,

Professor Matt Sabin
Group Director Medical Services and Clinical Governance

Cabrini

Consent to Procedure or Surgical Treatment

Unit Record Number_____

Surname_____

Affix patient label here or complete details

Given Names_____

DOB_____ Sex_____

FCH101201

Part A - To be completed by Treating Medical Practitioner

Interpreter used: ☐ Not required ☐ Yes If Yes, which language was the information translated to: _____

Interpreter service used: _____

Has anyone been appointed as a person responsible[1] for this patient's care? ☐ No ☐ Yes

If Yes, please specify who: _____

Does the patient have any written requests / requirements / instructions relating to their care[2]? ☐ No ☐ Yes

If Yes, please specify: _____

Where applicable, all written requests / requirements / instructions relating to the patient's care must be sighted

1. A person responsible may include an appointed medical treatment decision maker under the Medical Treatment Planning and Decisions Act 2016 (Vic) or a guardian with power to make medical treatment decisions appointed under the Guardianship and Administration Act 2019 (Vic)

2. Advanced Care Directives including any Instructional directives or Values directives under the Medical Treatment Planning and Decisions Act 2016 (Vic) or similar document

Description of the procedure or surgery, noting correct side / correct site. List all anticipated procedures or treatments (including the expected transfusion of blood or blood products and any possible secondary procedures).

The risks of this procedure / treatment have been discussed with the patient and these include:

- Infection
- Bruising or bleeding
- Pain / swelling / scars
- Risks associated with anaesthesia / sedation (if applicable you will have the opportunity to discuss these in more detail prior to your procedure)
- Other (please specify including any risks specific to the patient):

To be completed by Treating Medical Practitioners

I have explained the nature and purpose of the procedure / treatment detailed above and what it entails for the patient, the known benefits and risks of the procedure / treatment, the risks of not having the procedure / treatment, and the alternatives to having the procedure / treatment.

Full Name: _____

Name of **MEDICAL PRACTITIONER**

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **MEDICAL PRACTITIONER**

CONSENT TO PROCEDURE OR SURGICAL TREATMENT MR002DS

Allanby
CH1138
N/F
15/06/23

Cabrini

Consent to Procedure or Surgical Treatment

Unit Record Number_____

Surname_____

Affix patient label here or complete details

Given Names_____

DOB_____ Sex_____

FCH101201

Part B - To be completed by Patient or Person Responsible

I consent to the procedure and associated treatments as detailed in **Part A** of this form (overleaf).

In providing my consent to treatment, I acknowledge that the treatment has been explained to me by my treating medical practitioner and that I understand and have had the opportunity to ask questions about:

- The need for the procedure(s) or treatment(s);
- The known expected benefits and possible risks of the procedure(s) or treatment(s), including any risks specific to me;
- Alternative treatment options available and the expected benefits and possible risks of not having this procedure or treatment.

I further understand and agree to the following:

- My health information will be collected and used in accordance with Cabrini's Privacy Policy and applicable privacy laws.
- I may need additional procedure(s) / treatment(s) as is necessary in the reasonable opinion of my treating medical practitioner to preserve my health or life. This may include the transfusion of blood or blood products. **If you refuse the emergency / life-saving transfusion of blood or blood products, please notify your treating doctor so that your preferences can be documented.*
- If a staff member is exposed to my blood, a sample of my blood may be collected and tested for infectious diseases and that I will be informed of the test and results.
- Clinical information, including clinical photography / videography, blood or tissue specimens, may be collected during my procedure or treatment for diagnostic and treatment purposes. Additionally, this clinical information may be de-identified and used for the purpose of education and / or ethically approved research. **If you do not want your clinical information used in this way, please indicate your preferences below and notify your treating doctor:*

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of education.

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of ethically approved research.

Full Name: _____

Name of **PATIENT** or parent / guardian / person responsible

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **PATIENT** or parent / guardian / person responsible

Part C - Consent to the transfusion of Blood and Blood Products

(To be completed by Patient or Person Responsible, where indicated as appropriate by the treating Medical Practitioner. Strike out Part C if not applicable.)

I _____ have discussed the following with my doctor:

Name of **PATIENT** or parent / guardian / person responsible

- The likelihood that I require / may require a transfusion of blood or blood products in association with this treatment
- The reason(s) why I require / may require a transfusion of blood or blood products and the type of blood components and / or products required
- The general risks and benefits of receiving / not receiving blood or blood products
- The alternative treatments to having a blood transfusion and alternative blood management strategies

I have also been provided with written information about blood transfusions and have had the opportunity to ask my doctor any questions.

I understand the information provided to me and consent to the transfusion of blood or blood products as required, in association with the procedure / treatment outlined in **Part A** of this form (overleaf).

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **PATIENT** or parent / guardian / person responsible

**** If you REFUSE to consent to the transfusion of blood or blood products (or specific products) please discuss this with your treating doctor so that your preferences can be documented***

Consent to Medical Treatment and / or Blood Product Administration

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

FCH101200

Part A - To be completed by Treating Medical Practitioner

Interpreter used: ☐ Not required ☐ Yes If Yes, which language was the information translated to: _____

Interpreter service used: _____

Has anyone been appointed as a person responsible[1] for this patient's care? ☐ No ☐ Yes

If Yes, please specify who: _____

Does the patient have any written requests / requirements / instructions relating to their care[2]? ☐ No ☐ Yes

If Yes, please specify: _____

Where applicable, all written requests / requirements / instructions relating to the patient's care must be sighted

1. A person responsible may include an appointed medical treatment decision maker under the Medical Treatment Planning and Decisions Act 2016 (Vic) or a guardian with power to make medical treatment decisions appointed under the Guardianship and Administration Act 2019 (Vic)

2. Advanced Care Directives including any Instructional directives or Values directives under the Medical Treatment Planning and Decisions Act 2016 (Vic) or similar document

Description of medical treatment and / or blood products to be administered, including indication(s), and any likely secondary treatments

Expected duration of treatment(s), please tick to indicate:

☐ Single episode of treatment ☐ Current admission ☐ Ongoing Treatment*

***Consent is valid for a maximum of 12 months** providing that the patient's condition has not changed, and / or new information concerning the proposed intervention or alternative treatments have not come to light in the intervening period

The risks of this treatment has been discussed with the patient and these include:

- The expected reactions and side effects of the treatment
- Risks associated with intravenous access
- Risks associated with Blood and Blood Products (where applicable)
- Additional medications as required in association with this treatment
- Other (please specify including any risks specific to the patient):

To be completed by Treating Medical Practitioners

I have explained the nature and purpose of the treatment(s) detailed above and what it entails for the patient, the known benefits and risks of the treatment(s), the risks of not having the treatment(s), and the alternatives to having the treatment(s).

Full Name: _____

Name of **MEDICAL PRACTITIONER**

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **MEDICAL PRACTITIONER**

CONSENT TO MEDICAL TREATMENT AND / OR BLOOD PRODUCT ADMINISTRATION MR002DM

Allanby
CH1137
N/F
15/06/23

Cabrini

Consent to Medical Treatment and / or Blood Product Administration

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

FCH101200

Part B - To be completed by Patient or Person Responsible

I consent to the medical treatment(s), for the intended duration of treatment(s), as detailed in **Part A** of this form (overleaf).

In providing my consent to treatment, I acknowledge that the treatment has been explained to me by my treating medical practitioner and that I understand and have had the opportunity to ask questions about:

- The need for the treatment(s);
- The expected duration of the treatment(s);
- The known expected benefits and possible risks of the of treatment(s), including any risks specific to me;
- Alternative treatment options available and the expected benefits and possible risks of not having this treatment.

I further understand and agree to the following:

- My health information will be collected and used in accordance with Cabrini's Privacy Policy and applicable privacy laws.
- I may need additional treatment(s) as is necessary in the reasonable opinion of my treating medical practitioner to preserve my health or life.
- If a staff member is exposed to my blood, a sample of my blood may be collected and tested for infectious diseases and that I will be informed of the test and results.
- Clinical information, including clinical photography / videography, blood or tissue specimens, may be collected during my treatment for diagnostic and treatment purposes. Additionally, this clinical information may be de-identified and used for the purpose of education and / or ethically approved research. **If you do not want your clinical information used in this way, please indicate your preferences below and notify your treating doctor:*

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of education.

☐ I DO NOT consent to my de-identified clinical information being used for the purpose of ethically approved research.

Full Name: _____

Name of **PATIENT** or parent / guardian / person responsible

Signature: _____

Signature of **PATIENT** or parent / guardian / person responsible

Date of signature: DD/MM/YYYY

Part C - Consent to the transfusion of Blood and Blood Products

(To be completed by Patient or Person Responsible, where indicated as appropriate by the treating Medical Practitioner. Strike out Part C if not applicable.)

I _____ have discussed the following with my doctor:

Name of **PATIENT** or parent / guardian / person responsible

- The likelihood that I require / may require a transfusion of blood or blood products in association with this treatment
- The reason(s) why I require / may require a transfusion of blood or blood products and the type of blood components and / or products required
- The general risks and benefits of receiving / not receiving blood or blood products
- The alternative treatments to having a blood transfusion and alternative blood management strategies

I have also been provided with written information about blood transfusions and have had the opportunity to ask my doctor any questions.

I understand the information provided to me and consent to the transfusion of blood or blood products as required, in association with the medical treatment, for the intended duration of treatment, outlined in **Part A** of this form (overleaf).

Signature: _____ Date of signature: DD/MM/YYYY

Signature of **PATIENT** or parent / guardian / person responsible

If you REFUSE to consent to the transfusion of blood or blood products (or specific products) please discuss this with your treating doctor so that your preferences can be documented