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

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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