The Royal Children's Hospital Melbourne

UR NUMBER
SURNAME
GIVEN NAME(S)
DATE OF BIRTH
AFFIX PATIENT LABEL HERE ↑

# Patient Consent to Treatment or Investigation

I, _____, being the parent/legal guardian of
*[Full name of the person giving consent for this procedure/treatment]*

_____,
*[Full name of the person receiving this procedure/treatment]*

Consent for the following procedure(s)/treatment(s):

_____

_____

For the treatment of _____

The following risks related to this procedure(s)/treatment(s) have been explained:

_____

_____

Information titled "_____

_____" explaining this procedure(s)/treatment(s) has been provided.

**Complete the Patient Consent for Blood Products form (MR634/A) if either a crossmatch or group and hold is required.**

**Dr. _____ has discussed with me:**

- My/my child's condition and treatment options and I agree to the procedure(s)/treatments(s) above.
- The procedure(s)/treatment(s) risks and side effects, and complications which may occur.
- The specific risks of this/these procedure(s)/treatment(s) for me/my child.
- That an anaesthetic or medicines may be needed, and these may also have some risks.
- Additional procedure(s) or treatment(s) may be needed if the doctor finds something unexpected or the procedure(s)/treatment(s) does not go as planned.
- That the procedure(s)/treatment(s) may be performed by another doctor.
- Clinical information may be discussed at multidisciplinary team meetings.
- That I may withdraw my consent at any time prior to procedure(s)/treatment(s).
- That I may request further clarification about the procedure(s)/treatment(s) at any time.
- That blood, urine, other samples and clinical photographs/recordings may be taken for the diagnosis and treatment of myself/my child. These photographs/recordings and samples may be used for education and laboratory quality procedures (without identifying me/my child).

**I agree / I do not agree (please circle one option)** that tissue, blood or other samples taken routinely for this treatment(s)/procedure(s) can be used for ethically approved low risk research related to my child's condition/treatment/procedure. I understand I will not be contacted again, except if clinically relevant information may be available. I understand I can withdraw this consent at any time. ☐ (Insert initial here)

**I have been given the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. I hereby give my consent.**

Signature: (Parent/patient) _____ Date: ___ / ___ / _____

**BY DOCTOR:** I have a good understanding of the nature of the procedure(s)/treatment(s), its material risks and its complications. I have explained to the above named patient/parent/guardian the nature and effect of the procedure(s) and/or treatments(s). In my opinion he/she has understood this explanation and has signed in my presence.

Signature: (Doctor) _____ Date: ___ / ___ / _____

**Patient Consent to Treatment or Investigation 635/A**

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

**AFFIX PATIENT LABEL HERE** ↑

If interpreter service used

Name of Interpreter: _____ Date: / /

| On the day of procedure (to be completed by surgeon/proceduralist): | | |
|---|---|---|
| ○ | Confirm the patient's identity | Signature: |
| ○ | Confirm the above procedure(s) with parent/patient | Print Name: |
| ○ | Ensure the operative side/site is marked (if appropriate) | Date: / / |