Ulladulla Endoscopy and Medical Centre

111 Princes Highway
PO Box 110, Ulladulla, 2539
Tel.: 02 4455 5422, Fax.: 02 4454 2263
www.ulladullaendoscopy.com.au

PATIENT CONSENT

Family Name:
Given Name:
MRN
Gender:
DOB:
Address:

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr .....have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment

.....
INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT (DO NOT USE ABBREVIATIONS)

I have informed this patient of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

....
SIGNATURE OF MEDICAL PRACTITIONER DATE

....
SIGNATURE OF INTERPRETER (if needed) DATE

PATIENT CONSENT — To be completed by Patient

Dr .....and I have discussed my present condition and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- Colonoscopy patients only - pre-procedure bowel preparation is required and may have some complications
- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic or medicines may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care; and
- if I require admission to another hospital for further care, I will be responsible for the costs incurred.

Following the surgery, I understand that impairment of alertness may persist for several hours following anaesthesia. For the 24 hours following the procedure, I will:

1. Not drive a car or other vehicle, or operate a machinery
2. Not make any important or legal decisions
3. Not drink alcohol
4. Have a responsible adult to accompany me from my procedure
5. Have a responsible adult to stay with me overnight

I am aware that Dr Le and Dr Hoang have a pecuniary interest in Ulladulla Endoscopy and Medical Centre.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
I REQUEST AND CONSENT TO THE PROCEDURE/TREATMENT DESCRIBED ABOVE FOR ME.

....
Signature of patient Date

.....
Name of patient