## Acknowledgement of Consent to Treatment

Unit Record Number ______________________

Surname ______________________

Given Names ______________________

DOB ______________ Sex ______________

Affix patient label here or complete details

**Patient to complete and bring to hospital** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Do you require an interpreter to assist you in completing this form ☐ No ☐ Yes

If yes, has an interpreter been involved in completing this form ☐ No (Please provide reason ______________________ ) ☐ Yes

Has **anyone been appointed** to make a decision about your care?[1] ☐ No ☐ Yes

If yes, please specify: ______________________

______________________

______________________

Have you prepared any **written requests / requirements / instructions** relating to your care?[2] ☐ No ☐ Yes

If yes, please provide a copy

### Acknowledgement of consent to treatment

I ______________________ (Print name), on behalf of myself ☐ or ______________________ (Relationship to patient)

acknowledge that ______________________ (Name of Medical Practitioner or Medical Imaging Technologist*)

has explained to me the procedure(s) or treatment(s) detailed below to my satisfaction, and I consent to these. I understand the explanation the Doctor / Medical Imaging Technologist* gave me as to the need, benefits, risk and complications related to this procedure or treatment.

I also consent to the testing of my blood for infections, including HIV (AIDS) or Hepatitis, if a Medical Practitioner determines that any person is or may be at risk of infection through contact with me.

I further consent to the confidential use by staff at Cabrini of information contained in my Medical Record for the purposes of quality improvement.

*for IV contrast only

### Description of procedures or treatments on DD / MM / YYYY (Date of planned procedure)

______________________

______________________

______________________

______________________

Signature: ______________________ (Signature of patient / relative / guardian) Date of signature: DD / MM / YYYY

### Ackowledgement of consent to Anaesthesia or Sedation (To be completed after seen by Anaesthetist)

I consent to having an Anaesthetic or Sedation. I understand the explanation given to me by

Doctor: ______________________ (Print name of Doctor) as to the needs, benefits, risk and complications related to this.

Signature: ______________________ (Signature of patient / relative / guardian) Date of signature: DD / MM / YYYY

Note 1. An **agent** appointed under the Medical Treatment Act (Enduring Power of Attorney)
A **guardian** or an **enduring guardian** appointed under the Guardianship & Administration Act.

Note 2. Refusal of Treatment Certificate under the Medical Treatment Act or an Advance Care Plan or similar document.

FCH101200

ACKNOWLEDGEMENT OF CONSENT TO TREATMENT MR002D

Unit Record Number ______________________

Surname ______________________

Given Names ______________________

DOB ______________ Sex ______________

Affix patient label here or complete details

**Please bring this form to hospital on day of admission**

## Acknowledgement of informed consent for transfusion of blood or blood products

**Patient to complete** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Has the Doctor discussed the possibility that you may have a transfusion of blood products? ☐ No ☐ Yes

- The Doctor has explained why I may need / will need a blood transfusion
- The risk or benefits of receiving / not receiving blood or blood products have been discussed
- I have received an information brochure about blood transfusion
- The availability and appropriateness of any other blood management strategies have been discussed
- My questions have been answered

☐ Yes = I confirm all of the about have occurred

☐ No = Discuss with a member of staff prior to commencing / consenting to a transfusion.

**I consent** to having a transfusion of blood or blood products if required.

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

Signature of patient / relative / guardian

**Or**

**I refuse** to have a transfusion of blood or blood products at this time.

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

Signature of patient / relative / guardian

**Doctor to complete** - if patient is unable to complete any part of the consent, and there is no nominated enduring Power of Attorney (Medical) or relative / guardian immediately available.

**(For use in an emergency situation or when a patient is physically unable to sign).**

I ______________________ have discussed the proposed procedure / treatment

Print name of Doctor

with ______________________, ______________________,

Print name of person Relationship to patient

who has agreed that the procedure / treatment be undertaken.

Doctor's signature: ______________________ Date of signature: DD / MM / YYYY

Signature of Doctor

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# Pre-operative Medical Orders

Unit Record Number ____________________

Surname ____________________

Given Names ____________________

DOB ____________________ Sex ____________________

Affix patient label here or complete details

## Allergies and drug reactions

☐ Yes ☐ None known Name: ____________________ Signature: ____________________

| Drug substance | Reaction | Date | Drug substance | Reaction | Date |
|---|---|---|---|---|---|
| | | DD/MM/YYYY | | | DD/MM/YYYY |
| | | DD/MM/YYYY | | | DD/MM/YYYY |
| | | DD/MM/YYYY | | | DD/MM/YYYY |

Doctor to complete

**Patient to bring this form to hospital on day of admission**

| **Treatment order on admission** (E.g. pre-warming, sequential compression device) | **Doctor's name** | **Doctor's signature** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Test on admission** (E.g. ECG, Pathology) | **Doctor's name** | **Doctor's signature** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Preoperative medications only** - to be given on admission (Eye drops, enema and topical preparations only)

| **Date prescribed** | **Medication order** | | | **Prescribing Doctor** | | **Record of administration** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Drug Name | | | Prescriber number | Doctor's name | Date | Time | Time | Time | Time |
| | Dose | Frequency | Route | | Doctor's signature | | Given by | Given by | Given by | Given by |
| DD/MM/YYYY | | | | | | DD/MM/YYYY | ___:___ | ___:___ | ___:___ | ___:___ |
| DD/MM/YYYY | | | | | | DD/MM/YYYY | ___:___ | ___:___ | ___:___ | ___:___ |
| DD/MM/YYYY | | | | | | DD/MM/YYYY | ___:___ | ___:___ | ___:___ | ___:___ |
| DD/MM/YYYY | | | | | | DD/MM/YYYY | ___:___ | ___:___ | ___:___ | ___:___ |

**List ALL medicines currently used, including:**
**prescription medicines, over-the-counter medicines, herbal and natural medicines.**

**Medicines come in many forms including:**
**tablets, liquids, inhalers, drops, patches, creams, suppositories and injections.**
**List any medication allergies.**

**Allergies and drug reaction** ☐ Yes ☐ None known

| Drug substance | Reaction | Date | Drug substance | Reaction | Date |
|---|---|---|---|---|---|
| | | DD/MM/YYYY | | | DD/MM/YYYY |
| | | DD/MM/YYYY | | | DD/MM/YYYY |
| | | DD/MM/YYYY | | | DD/MM/YYYY |

**Medication list**

**Patient to complete this form and bring to hospital on day of admission**

Surname:________________ Given names:________________ Date of birth: DD / MM / YYYY

Your address:________________ Postcode:________ Name of your Pharmacy:________________

| Name of medicine, active ingredient or brand name | Strength | What is this medicine for? | How much do I use and when? | Special instructions or comments | Date started | When to stop or review |
|---|---|---|---|---|---|---|
| | | | | | DD/MM/YYYY | |
| | | | | | DD/MM/YYYY | |
| | | | | | DD/MM/YYYY | |
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| | | | | | DD/MM/YYYY | |

**Office use only**

Pre-admission Number: ______________________

UR Number: ______________________

# Registration Form

**Patient to complete and post in reply paid envelope**

Date of surgery: DD / MM / YYYY

**Admitting campus**

☐ **Cabrini Malvern** ☐ **Cabrini Brighton**

## Section 1: **Patient details - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Please tick ✓

Title:________ Surname: ______________________

Given names: ______________________ Date of birth: DD / MM / YYYY ☐ Male ☐ Female

Residential address: ______________________ Postcode: __________

Postal address (If different to above): ______________________

______________________ Postcode: __________

Tel (Home): ______________ Tel (Work): ______________ Mobile: ______________

Email address: ______________________

**What date are you being admitted?** DD / MM / YYYY

Who is your admitting Doctor? ______________________

**Maternity patients:** What is your expected delivery date? DD / MM / YYYY

Have you been a patient at Cabrini in the **last 3 months**? ☐ Yes ☐ No

**If yes,** only complete details that have changed and sign the declaration in section 9
**If no,** please complete all sections

Have you **previously** been a patient at Cabrini? ☐ Yes ☐ No

Was your name the same? ☐ Yes ☐ No

If no, what was your previous name? ______________________

Marital status: ______________ Religious affiliation: ______________ ☐ I do not wish to declare a religious affiliation

Country of birth: ______________________

Do you require an interpreter? ☐ Yes ☐ No Preferred language: ______________________

Are you of Aboriginal or Torres Strait Islander descent? ☐ Yes ☐ No

## Section 2: **Health cover details - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Name of health fund: ______________________ Membership number: ______________________

Medicare card number: |___|___|___|___| - |___|___|___|___|___| - |___| Ref no |___| Valid to: MM / YYYY

Ambulance cover: ☐ Yes ☐ No Details: ______________________

Veterans' affairs file number: ______________________ ☐ Gold card ☐ White card ☐ Orange card

Pension / healthcare card number: ______________________ Exp: DD / MM / YYYY

Pharmaceutical safety net: Concession number (CN) ______________________ Exp: DD / MM / YYYY

Safety Net (SN) number ______________________ Exp: DD / MM / YYYY

## Section 3: **GP details - patient to complete** (Parent or guardian to complete for persons under 18 years)

Do you consent to your GP being informed of your admission? ☐ Yes ☐ No

GP name: ______________________ GP address: ______________________

______________________

GP contact number: ______________________ GP Fax number: ______________________

Please turn over





FCH100900

Cabrini

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**Patient to complete and post in reply paid envelope**

Section 4: **Emergency contact - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Title:_______ Surname: ______________________________ Given names: ______________________________

Address:______________________________________________________________ Postcode: __________

Relationship to patient: ______________________________________________________________

Tel (Home):_________________________ Tel (Work):_______________________ Mobile: ______________________

**Additional contact**

Title:_______ Surname: ______________________________ Given names: ______________________________

Address:______________________________________________________________ Postcode: __________

Relationship to patient: ______________________________________________________________

Tel (Home):_________________________ Tel (Work):_______________________ Mobile: ______________________

Section 5: **Account details - Patient to complete** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Who is responsible for paying your account? ☐ Self ☐ Next of kin ☐ Workcover ☐ TAC ☐ Veterans' affairs ☐ Other

If other, is this person aware that they are responsible for paying this account? ☐ No ☐ Yes

Title:_______ Surname: ______________________________ Given names: ______________________________

Address:______________________________________________________________ Postcode: __________

Relationship to patient: ______________________________________________________________

Tel (Home):_________________________ Tel (Work):_______________________ Mobile: ______________________

Section 6: **Insurance / claim details - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Please contact your health fund prior to admission to check your level of cover, as excess, gap or co-payment may apply which must be settled prior to admission. If you are not insured and do not have adequate cover, you must also settle all costs prior to or on admission.

☐ Overseas patient ☐ Veterans' affairs ☐ Nil insured ☐ Privately insured

Fund name: ______________________________________ Membership number: ______________________________

Level of cover: ______________________________________________________________________________

Section 7: **Workcover / TAC - Patient to complete** (Parent or guardian to complete for persons under 18 years)

☐ Workcover ☐ TAC Claim number: ______________________________________________________________

Date of injury: DD / MM / YYYY Name of insurance company: ______________________________________________

Employer's name: ______________________________________________________________________________

Employer's address:________________________________________________________________ Postcode: ___________

Contact person:________________________ Contact number:_________________ Fax number: ____________________

Has your employer accepted liability? ☐ No ☐ Yes (If Yes, please attach acceptance letter)

Section 8: **Cabrini foundation - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Cabrini may contact you to support our community activities and hospital developments. We respect your privacy, so please let us know if you do not wish to be contacted for these reasons. ☐ **I do not** wish to be contacted by the Cabrini Foundation.

Section 9: **Declaration - Patient to complete** (Parent or guardian to complete for persons under 18 years)

I agree that information provided within this form is true and correct to the best of my ability.

Name:____________________________ Signature:_______________________________ Date: DD / MM / YYYY

Place signed form in reply paid envelope and post.