East Sydney Private Hospital

Clear Form

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Admissions Office
Level 4, 75 Crown St, Woolloomooloo NSW 2011
Email: admit@esphospital.com
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REQUEST/CONSENT FOR MEDICAL PROCEDURE/TREATMENT

INFORMATION TO BE PROVIDED BY DOCTOR TO PATIENT (PART A)

I, Dr _____ have informed _____

about the recommended procedure or treatment detailed by me below, including its nature, likely results and material risks.

_____

_____
(Name of procedure/treatment)

Procedure Site _____

Procedure side of body: ☐ Right ☐ Left ☐ Both ☐ Not Applicable

Signature of medical practitioner: _____ Date: _____

*If Interpreter present _____ _____ Date: _____
(Name of interpreter) (Signature of interpreter)

(* Delete where applicable)

TO BE COMPLETED BY PATIENT/PERSON RESPONSIBLE (PART B)

I _____ and Dr _____ have discussed *my / patient's condition

The Doctor has recommended the procedure/treatment detailed above.
The doctor has advised me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed and these may have some risks;
- additional procedures or treatment may be needed if the Doctor finds something unexpected;
- the procedure/treatment may not give the expected results even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.
I have 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 (patient) do NOT consent to having a blood or blood products transfusion
I request and consent to the procedure/treatment described above for *me / my child. I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

_____ _____ Date: _____
(Signature of * patient/parent /guardian) (Name of * patient/parent /guardian)

_____
(* Delete where applicable) (Address)

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

East Sydney Private Hospital staff will be required to collect personal information as part of your pre-admission and hospital stay. In an emergency situation, we may need to collect personal information from relatives or other sources where we are unable to obtain your prior expressed consent. In the course of your surgery & medical treatment, clinical data and images may be recorded as part of your admission and medical record.

CONSENT: I provide my consent for health professionals of East Sydney Private Hospital to collect, use and disclose my personal information as outlined above and in accordance with NSW and Commonwealth privacy acts – NSW *Health Records and Information Privacy Act 2002* and the *Privacy and Personal Information Protection Act 1998* & Privacy Amendment (enhancing privacy protection) Act 2012. Please ask for a copy of the Privacy Policy if you would like more information.

Name of * patient/parent /guardian: _____

Signature of * patient/parent /guardian: _____ Date: _____

(Part C) The ESPH online admission form and Patient Health Questionnaire must be completed by patients at least 7 days prior to admission at: esph.admission.com.au. Or use QR code for link: