GILLIES
A SOUTHERN CROSS HOSPITAL

FORM 1
AGREEMENT TO TREATMENT

Return all forms to arrive at Gillies Hospital at least ONE WEEK before admission

This section is completed by your Surgeon

Surname (family name): _____ First name(s): _____

Planned Procedure: _____

_____

_____

_____

_____

_____

Operative side of body: ☐ Left ☐ Right ☐ Bilateral ☐ Not applicable

Proposed Date of Surgery: _____ ☐ Day stay patient ☐ Overnight stay ☐ No. of nights

Interpreter required: ☐ Yes ☐ No Language required _____ (Hospital to organise)

Proposed Anaesthesia: ☐ General ☐ Local ☐ Regional ☐ Spinal ☐ Epidural ☐ LAS

Surgeon's Instructions: _____

_____

_____

_____

Surgeon Name: _____ Signature: _____ Date: d / m / y

This Section is completed by the patient/guardian with your surgeon

I, _____ agree to have the procedure/operation/ treatment described above
(Patient's / Guardian's full name)

performed on myself / my child _____
(Please circle) (Name of patient, if patient not signing form)

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/ treatment and alternatives, and the possibility and nature of further related treatment including a return to theatre, should any complications arise.

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I agree to the administration of blood or blood products that may be required.

I agree to the procedural images being taken as required, and to be held by my surgeon.

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk e.g. hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to Gillies Hospital or any health professional involved in my care for this admission to hospital, to access health information about me that is relevant to my current treatment, which may be held by Gillies Hospital, other health professionals or other health organisations.

I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.

Patient/Parent/Guardian signature: _____ Date: d / m / y

If not patient, state relationship to patient: _____
(Please provide evidence of enduring power of attorney if appropriate)

Surgeon's signature: _____ Date: d / m / y

Hospital use only: Received: d / m / y