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to the



Family name:

URN:

Generic Cardiac Consent	Given name(s):
	Address:
Facility:	Date of birth: Sex: M
A. Interpreter / cultural needs  An Interpreter Service is required?  Yes	Heart attack or stroke could occur due strain on the heart.      Blood clot in the leg (DVT) causing parts.
If <i>Yes</i> , is a qualified Interpreter present?  Yes    B. Condition and treatment	No swelling. In rare cases part of the clot off and go to the lungs.
This condition requires the following procedure. (Doctor to document - include site and/or side when relevant to the procedure)	Death as a result of this procedure is (possible/very rare).  re
	D. Significant risks and procedure
	(Doctor to document in space provided. Co Medical Record if necessary.)
The following will be performed:	
	E. Risks of not having this procedu
	(Doctor to document in space provided. Co Medical Record if necessary.)
C Risks of the recommended procedure	

In recommending this procedure your doctor has balanced the benefits and risks of the procedure against the benefits and risks of not proceeding. Your doctor believes there is a net benefit to you going ahead.

There are risks and complications with this procedure. They include but are not limited to the following.

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Dabigatran, Rivaroxaban, Apixaban, Asprin, Clopidogrel, Prasugrel, Ticagrelor or Dipyridamole.
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.

F.	Anaesthetic

This procedure may require an anaesthetic. (Doctor to document type of anaesthetic discussed)

(Affix identification label here)



# **Generic Cardiac Consent**

	(Affix identification labe	el here)		
URN:				
Family name:				
Given name(s):				
Address:				
Date of birth:		Sex: M	ΠF	Пі

Facility:

### G. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- other relevant procedure options and their associated risks.
- my prognosis and the risks of not having the procedure.
- that no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheet/s:

Local Anaesthetic and Sedation for you procedure OR
About your Anaesthetic
Blood & Blood Products Transfusion

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

I request to have the procedure		
Name of Patient:		
Signature:		
Date:		
Patients who lack capacity to provide consent		
Consent must be obtained from a substitute decision maker/s in the order below.		
Does the (AHD)?	patient have an Advance Health Directive	
☐ Yes►	Location of the original or certified copy of the AHD:	
□ No ►	Name of Substitute Decision Maker/s:	
	Signature:	
	Relationship to patient:	
	Date: PH No:	
	Source of decision making authority (tick one):	
	☐ Tribunal-appointed Guardian	
	Attorney/s for health matters under Enduring Power of Attorney or AHD	
	☐ Statutory Health Attorney	
	If none of these, the Adult Guardian has provided consent.	
L		

## H. Doctor/delegate statement

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of

Doctor/delegate:

Designation:

Signature:

#### Interpreter's statement

I have given a sight translation in

(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

guardian/substitute decision-maker by the doctor.
Name of Interpreter:
Signature:
Date: