



FAMILY NAME	[REDACTED]	MR	[REDACTED]
GIVEN NAME	[REDACTED]	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
DOB	[REDACTED]	M.O.	Feller
ADDRESS			

Facility: SVM

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adult and Mature Minors)

LOCATION / WARD: Emergency

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

For patients with capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT To be completed by Medical Practitioner

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

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

Gastroscopy + intragastric balloon removal

I have informed this patient of the nature, likely results and material risks of the proposed procedure / treatment and of the matters in the consent form.

I have assessed this patient and they give consent (a 'mature minor') as they have demonstrated sufficient understanding of what is proposed. Yes No NA

SIGNATURE: [REDACTED] DATE: 25.1.2024 TIME: 13:06

Interpreter* [REDACTED] DATE: / / 20 TIME: Emp ID/Prov No.

PATIENT CONSENT To be completed by Patient

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

The doctor has told 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 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.

I understand the nature of the procedure/treatment and that undergoing the procedure/treatment carries risks. 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 have been told that another doctor may perform the procedure/treatment.*

I **consent** to the procedure/treatment described above and I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment for me.

DELETE IF NOT REQUIRED *This section must be countersigned by your doctor as acknowledgment of refusal.*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I **refuse consent** to have the following aspects of the recommended procedure or treatment:

INSERT OBJECTION

SIGNATURE OF MEDICAL PRACTITIONER

- I consent to a blood transfusion if required.
- I DO NOT consent to the transfusion of blood or ANY blood products.
- I will accept SOME blood, blood products and procedures/treatments as indicated on SMR020.010 Refusal of Blood and/or Blood Products.

(Where a Mature Minor refuses blood/blood products, medical practitioner to seek advice from NSW Health Legal and Regulatory Services)

SIGNATURE OF PATIENT: [REDACTED] DATE: 25.1.2024 TIME: 13:06 AM (PM)

PRINT NAME OF PATIENT

* Delete where not applicable

SMR020001

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

NH606006 141124

TREATMENT FOR MEDICAL PROCEDURE / (Adult and Mature Minors)

SMR020.001