PERTH EYE HOSPITAL

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PATIENT CONSENT FORM

Please complete this form and return to the Perth Eye Hospital at least one week prior to the date of your procedure

CONSENT TO TREATMENT AND BLOOD TEST

I, _____ _____
(Name of patient) *(Date of Birth)*

consent to the procedure/operation of _____

_____

being performed on _____
(If not self, state name of patient)

The nature and purpose of the surgery and potential risks and complications from the surgery have been explained to me by:

Dr _____

I understand the information which has been provided to me, including the risks and complications, and have formed a decision to proceed with the surgery proposed.

I also consent to such further or alternative operative measures as may, in the opinion of the Surgeon, be found to be necessary during the course of such operation, and to the administration of a local or other anaesthetic.

If any staff member or doctor is injured and exposed to my/the patient's' blood, then I give consent to blood being collected and tested for infectious agents including hepatitis and HIV antibody.

I understand that:

1. I will be informed that blood has been taken for testing.
2. The results of the test will be made available to me, the staff member or doctor and the executive director of this hospital.
3. All staff and doctors are bound by hospital policy to maintain confidentiality of the test results.

Signature _____ Date _____
(Patient/Person Responsible)

CONSENT TO VISITORS IN THEATRE

From time to time your surgeon may invite a visiting medical officer or product specialist to observe your/the patient's surgery, or a surveyor from an accrediting body may wish to view theatre processes during your/the patient's surgery. Patient privacy is important and we ask that you indicate your/the patient's preference with regards to observers attending your/the patient's surgery.

☐ Yes, I give permission for observers to attend during my/the patient's surgery.

☐ No, I do not give permission for observers to attend during my/the patient's surgery.

DOCTOR'S CONFIRMATION / AUTHORISATION

I confirm that I explained the nature, purpose and risks and complications of this procedure/operation to the patient/person responsible, and that the patient/person responsible has advised me that he/she understands the information and agrees to proceed with the procedure/operation.

I authorise the following to be administered as per my preference sheet (please tick):

☐ Eye Drop Regime ☐ Pre-operative / post-operative medication

Signature _____ Date _____
(Medical practitioner)

Name (please print) _____