THE ROTUNDA HOSPITAL DUBLIN

Patient Addressograph

PATIENT CONSENT FORM

Proposed Investigation, Treatment or Operation

_____

_____

Indication for Investigation, Treatment or Operation

_____

_____

Specific Risks Associated with Investigation, Treatment or Operation

_____

_____

Section 1: for completion by Clinician

I confirm that I have explained the reason and potential benefits of the above investigation, treatment or operation to the named patient / the patient's legal guardian, as well as other alternative options, including no treatment. This discussion included the possible risks involved, in addition to the risk associated with no treatment. The explanation I have given is, in my judgement, suited to the understanding of the patient and/or the parent(s) or guardian(s) of the patient.

Clinician's signature:_____ Date: _____

Clinician's name: (PRINT)_____ Registration/IMC_____

Special communication needs (please specify)

_____

N/A ☐ Interpreter by phone ☐ Interpreter present ☐

Patient is a minor *(as per Consent Policy)* Yes ☐ No ☐

Is involvement of parent/guardian required? *(as per Consent Policy)* Yes ☐ No ☐

Section 2: For completion by Patient/Parent/Guardian

For completion by patient (or parent/guardian) after section 1 has been completed by the clinician.
Please tick each box to indicate your agreement with each statement below.

☐ I have listened to and understood the explanation that I have been given in respect of the above investigation, treatment and operation. I know that I can ask for clarification of anything I do not understand. I have checked the details of this form and have confirmed that they are accurate.

☐ I consent to undergo anaesthesia or sedation as required for this procedure and understand that there are inherent risks which I may discuss with the anaesthetist.

☐ I understand that any procedure done in theatre carries with it risk. These may include bleeding, damage to adjacent organs and/or infection.

☐ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

☐ No assurance has been given to me that the operation will be performed by a particular doctor.

☐ I have received an information leaflet/verbal explanation regarding the proposed investigation/treatment/operation

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Signature of patient _____

Signature of parent/guardian (if minor): _____

PRINT NAME: _____

Date: _____

Section 3:
A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Witness signature: _____ Date: _____

Name (PRINT) _____

Information leaflet given: Yes ☐ No ☐