RV [redacted] Page: [redacted]

The ROYAL HOSPITALS

CONSENT FORM

FOR MEDICAL OR DENTAL INVESTIGATION, TREATMENT OR OPERATION OR FOR TREATMENT BY A HEALTH PROFESSIONAL OTHER THAN DOCTORS OR DENTISTS

BLOCK CAPITALS [redacted]

Directorate _____

Patient's surname [redacted] Other names [redacted]

Date of birth [redacted] Unit No [redacted]

Sex (please tick) Male [redacted] Female [redacted]

Doctors/Dentists/Health Professionals to complete this part

The type of operation, investigation or treatment for which written evidence of consent is considered appropriate [redacted]

I confirm that I have explained the operation, investigation and/or proposed treatment and such appropriate options as are available and the type of anaesthetic (general/local/sedation) proposed to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature [redacted] Date [redacted]

Name and grade of doctor, dentist or health professional (PRINT) [redacted]

Patient/Parent/Guardian

I am the patient/parent/guardian (*delete as necessary*)

1. **Please read this form and the notes overleaf very carefully.**
2. If there is anything that you don't understand about the explanation, you should ask the doctor/dentist/health professional.
3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I agree	- to what is proposed and which has been explained to me by the doctor/dentist/health professional named on this form - to the use of the type of anaesthetic of which I have been informed.
I understand	- that the procedure may not be carried out by the doctor/dentist/health professional who has been treating me. - that any procedure in addition to the investigation or treatment described in this form will only be carried out if it is necessary, in my best interests, and can be justified for medical reasons.
I have informed	- the doctor/dentist/health professional that the procedures listed below should not be performed without my prior consideration.

_____

_____

_____

Signature [redacted]

Name [redacted]

Address (*if not the patient*) [redacted]

Medical or dental treatment of patient who is unable to consent because of a mental disorder - Consent F

CONSENT FORM

Notes to Doctors/Dentists/Health Professionals

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form. (Further guidance is given in HSS(GHS)2/95: A Guide to consent for Examination or Treatment).

Notes to Patients

The doctor/dentist/health professional named on this form is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse the treatment.

You may ask for a relative, friend or another member of staff to be present.

Training doctors, dentists and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a fully qualified doctor/dentist/health professional.

You may however decline to be involved in the formal training of medical, dental and other students without this adversely affecting your care and treatment.

Note

FOR MEDICAL OR DENTAL TREATMENT OF A PATIENT WHO DOES NOT HAVE THE CAPACITY TO CONSENT BECAUSE OF UNCONSCIOUSNESS, MENTAL DISORDER etc.

- It is the **personal responsibility** of any doctor, dentist or health professional proposing to treat a patient to determine whether the patient has the capacity to give a valid consent.
- It is good practice to consult relatives and others who are connected with the care of the patient. Sometimes consultation with a specialist or specialists will be required.
- The form should be signed by the doctor/dentist/health professional who carries out the treatment.

Doctors/Dentists/Health Professionals

Describe investigation, operation or treatment proposed.

_____

_____

_____

_____

_____

Complete this part of the form

In my opinion _____ is not capable of giving consent to treatment.

In my opinion the treatment proposed is in his/her best interests and should be given.

The patient's next of kin have/have not been so informed (*delete as necessary*)

Signature _____ Date _____

PRINTED

Name and grade of doctor/dentist/health professional _____

_____