RANCHBELT PTY LTD. ACN 57 067 738 345
T/AS
SUSSEX DAY SURGERY
Level 5, Sussex Centre, 401 Sussex Street
Haymarket NSW 2000 Australia
Phone: (02) 9281 3822 Fax: (02) 9281 5922

Patient Label

CONSENT FOR SURGICAL OPERATION / PROCEDURE AND ANAESTHESIA (INCLUDING MINORS)

I _____

have been fully informed of the nature my / my child's condition and have agreed to the operation / procedure of _____
performed upon myself / my child.

Following a discussion of my / my child's present condition including the nature and likely results of the operation / procedure, I accept the professional opinion of Dr. _____ that this is the appropriate operation / procedure.

I also request and consent to the administration of anaesthetics, medicines, blood transfusion or other forms of treatment normally associated with this operation / procedure.

I understand that other unexpected operations / procedures may be necessary and I request that these be carried out if required. I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this operation/procedure. I understand that should I require admission to hospital for further care, I will be responsible for the costs incurred.

Following surgery I will be escorted home by a reponsible adult and have made arrangements for this. I understand that impairment of mental alertness may persist for up to 24 hours after anaesthesia and I will avoid making decisions or taking part in activities which depend upon full concentration or judgment during that period.

Full payment for your stay at Sussex Day Surgery must be made at the time of your admission.

Signature of Patient/Guardian _____

Signature of Doctor _____ Date _____

同意書

* 我 / 我孩子_____ 經過醫生詳細解釋，我明白我 / 我孩子需要進行 _____ 手術 / 檢查。
* 我同意由 _____ 醫生施行這項手術 / 檢查。
* 我同意手術 / 檢查中必須的治療措施如麻醉，某些藥物的使用，輸血或其他。
* 我明白手術中有時需要進一步的檢查，如果該項手術是必需的，我同意醫生即時進行。
* 我同樣明白手術中可能出現的併發症。我明白如果出現這種狀況，我 / 我孩子有可能被送去醫院接受進一步的治療，而我將會負責醫院全部費用。
* 我需要安排親人 / 朋友於手術後陪同回家及護理。我明白麻醉後 24 小時內不能進行劇烈活動或簽署任何重要文件。

病人 / 監護人　　簽署_____　　醫生簽名 _____
日期_____　　手術日期 _____

CONSENT / OPERATION NOTE / ANAESTHESIA RECORD

MR001

THEATRE CHECK LIST

Patient Label

☐ Identification Band

☐ Contact lenses/Glasses

☐ Jewellery Removed/Taped

☐ Dental Caps, Crowns ☐ Bladder emptied ☐ Allergy

☐ Dentures ☐ Fasted since _____ ☐ Consent

☐ Escort Arranged _____

Telephone _____

☐ Blood Pressure _____ mm Hg

Pulse _____

Weight _____ Kg Temp. _____

☐ Clinical handover to Anaesthetist

CHECKED BY _____ (ADMIT NURSE) TIME: _____

Pressure Injury:

Open Wounds _____

Pressure areas: _____

History of Infection:

(eg MRSA, VRE, HEP B, HIV)

Others _____

Comments: _____

OPERATION NOTES (TO BE COMPLETED BY MEDICAL SPECIALIST)

SURGEON _____ ASSISTANT(S) _____

PRINCIPAL DIAGNOSIS _____

_____

SPECIMEN TO PATHOLOGIST _____

MBS Item No.

PRINCIPAL OPERATION / PROCEDURE

POST OPERATIVE INSTRUCTIONS

SURGEON SIGNATURE
DATE / /