RESERVOIR PRIVATE HOSPITAL
DAY PROCEDURE CENTRE

Patient to Complete:

Name: .... Date of Birth: ....

Address:...

Phone: ....

ACKNOWLEDGEMENT OF CONSENT FOR COLLECTION OF HEALTH INFORMATION

Privacy Amendment (Private Sector) Act 2000 Health Record Act 2001 (Vic)

I, ... Acknowledge that I have been informed of the following:

- The organisation collecting the information is Reservoir Private Hospital Day Procedure Centre
- You the patient or authorised person has the right to gain access to the patient's health information.
- The purpose for which the information is collected is to maintain your episode of care whilst an inpatient
- Reservoir Private Hospital Day Procedure Centre by law has to divulge particular information to State/ Federal Health

I hereby consent to Reservoir Private Hospital Day Procedure Centre using the information collected from me for the purpose outlined to me.

I agree to be personally responsible for payment of all hospital treatment regardless of any claim I may have against any health fund or third party. The answers that I have given to all questions are true to the best of my knowledge and I have not withheld any information.

Signature of Patient/Authorized Person X .... Witness.................................... Date

CONSENT FOR PROCEDURE

PART A: To be completed with Doctor

The doctor whose name appears in Part B and I have discussed my present condition and the way which it might be treated including:

1. The administration of an anaesthetic and medicines may be needed with this procedure and those carry some risks.
2. Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional procedures and/or treatment being carried out if required for example: Banding, Haemostatic clip/s, Biopsy, injectable/s, Argon, Antibiotics, polypectomy which may incur an additional cost and must to be paid on the day.
3. The procedure carries certain risks, the nature of those risks and complications that may occur to me including damage to teeth due to the presence of instruments in my mouth.
4. I may be responsible for the cost of pathology tests depending on my Health fund if applicable.
5. I will be responsible for the cost of an ambulance if needed if my health fund does not cover the cost or I do not have Ambulance Victoria membership.

I agree that I have been given the opportunity to ask questions of the doctor whose name appears below and understand the nature of the procedure and undergoing the procedure carries risks. I am satisfied with the answers and information I have received. I have been advised of the material risks associated with this procedure.

I understand that whilst I am in hospital, I will receive care, medications, tests and examinations as necessitated by the procedure I am undertaking. Following the procedure I have been advised I must have a responsible adult take me home and have somebody with me overnight. I realize that impairment of full mental alertness may persist for the rest of the day. I will not drive a car, operate machinery, drink alcohol or sign any legal documents on the same day of the procedure

I acknowledge that Reservoir Private Hospital Day Procedure makes available to me Patient Rights and Responsibilities as well as Health Information Collection Disclosures.

Signed…………………………………………………………………………......Relationship to patient…………………………….. Date……………

Witness Signature……………………………………………………………….Print Name……………………………………………………………………….

*witness is verifying that they have witnessed the patient/guardian signing the form

PART B: To be completed by Proceduralist

I, Doctor…………………………………have informed (Patient) .... **of the nature and material risks of the recommended procedure. The agreed procedure and treatment that the patient is to undergo is:** ....

To be performed with or without: Biopsy, Polypectomy, Banding, Haemostatic clip/s, Injectable/s, Argon

Proceduralist Signature:.. **Print Name** .... **Date**: ....

PART C: To be completed by Anaesthetist

I have discussed with the patient the relevant aspects and risks of the anaesthetic and he/she has given consent to proceed.

Anaesthetist Signature .... **Print Name** ....Date:...............................