

# FORM B

<b>Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation</b> (Page 1 of 2)	<b>Affix hospital identification here</b>		
	<b>Surname</b>		<b>UMRN</b>
	<b>Given names</b>	<b>DOB</b>	<b>Sex</b>
	<b>Address</b>		
	<b>Suburb</b>		<b>Postcode</b>

This form is to be completed giving due consideration to the “*Consent to Treatment Policy for the Western Australian Health System*”

**Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)**

*Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure*

- I have informed the parent/guardian of the child’s medical condition and prognosis. I have also explained the relevant diagnostic treatment options that are available for the child and associated benefits and risks.
- I have recommended the treatment/procedures/investigations noted below on this form. I have discussed the proposed procedure/s and outcomes (including irreversibility) with the parent/guardian. The benefits and risks, both general and specific, and the risks of not having the procedure have also been explained to the parent/guardian.
- The parent/guardian has been provided with information specific to the procedure identified. He or she has been asked to read information I have provided and to advise me or the doctor/proceduralist (if different person) if further information is required.
- An identifiable copy of the information I have provided to the parent/guardian has been kept on the patient’s medical record.

**Treatment/procedure/investigation**

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires:     General and/or Regional Anaesthesia     Local Anaesthesia     Sedation  
 An anaesthetist will explain the risk of general or regional anaesthesia to you.

**Disclosure of material risks**

Material risk or specific risks particular to this patient that have arisen as a result of our discussions are:

**Signature of doctor/proceduralist obtaining consent**

Full name (please print) \_\_\_\_\_ Position/Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Signature of doctor/proceduralist with overall responsibility for treatment (If different)**

Full name (please print) \_\_\_\_\_ Position/Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Parent/guardian's declaration**

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor/proceduralist performing the procedure **prior to signing the consent form.**

- The doctor has explained the child's medical condition and prognosis to me. The doctor also explained the relevant diagnostic treatment options that are available to the child and their associated risks, including the risks of not having the procedure.
- The risks of the procedure have been explained to me, including the risks that are specific to the child and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
- I **understand** that the result/outcome of the treatment/procedure cannot be guaranteed.
- I **understand** that if immediate life-threatening events happen during the procedure, the child will be treated as necessary to save the child's life or to prevent serious harm to the child's health.
- I **understand** that if the child is treated as a public patient no guarantee can be provided that a particular doctor/proceduralist will perform the procedure and that the doctor/proceduralist performing the procedure may be undergoing training.
- I **understand** that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.
- I **agree** for my/this child's medical record to be accessed by staff involved in the child's clinical care and for it to be used for approved quality assurance activities, including clinical audit.
- If a staff member is exposed to my/this child's blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.
- I **consent** to the child having a blood transfusion       Yes       No (**please tick relevant box**)
- On behalf of the child, I give **consent** for my/this child to undergo the procedure/s or treatment/s as documented on this form.
- I **understand** that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs.

**Parent/guardian's full name** \_\_\_\_\_

**Parent/guardian signature** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

**Interpreter's declaration**

Specific language requirements (if any) \_\_\_\_\_

Interpreter services required:       Yes       No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

**Interpreter's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Full name** (please print) \_\_\_\_\_

**Confirmation of consent at pre-admission or admission to hospital**

I confirm that the request and consent for the operation/procedure/treatment above remains current.

**Signature** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

(parent/guardian)