Right

VPSC VICTORIA PARADE SURGERY CENTRE

Level 1, 100 Victoria Parade
EAST MELBOURNE VIC 3002
T: (03) 9650 4000
E: reception@vpsc.com.au

Operation/Procedure Consent

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Part 1 – to be completed by Accredited Health Practitioner

Information provided about the operation/procedure

Name of Patient: Mr Bryan BOTTERILL

Name of Patient's Substitute Decision-Maker (if applicable):

Name of Accredited Health Practitioner performing operation/procedure: Dr Colby Hart

The presenting symptoms or condition to be treated (if applicable):
Cataracts

Date of surgery: / / 18/11/2024

The proposed operation/procedure is: RIGHT CATARACT REMOVAL + IOL

Assessment of capacity to consent

I have assessed the capacity of the patient's ability to consent to the operation/procedure and have formed the view that:

☒ The patient **has** capacity to consent; *OR*

☐ The patient **does not have** capacity to consent, and so consent has been provided by the patient's:

.....

(insert relevant legal basis: parent, legal guardian, enduring power of attorney, statutory health attorney or substitute decision-maker)

Signature of Accredited Health Practitioner

I have discussed with the patient (or where the patient lacks capacity, the person who can legally make decisions on their behalf) the patient's condition, care options (including the proposed operation/procedure), the material risks of the options and any risks that are specific to the patient, the benefits of the options, the expected outcome of the proposed operation/procedure and the expected outcome of not undergoing the operation/procedure.

Signature of Accredited Health Practitioner: Colby Hart Date: 4/09/2024

Part 2 – to be completed by, or on behalf of, the patient

Consent to the operation/procedure

I request that the above operation/procedure be performed on the patient noted above.

By signing this form, I confirm that I have been advised (with the assistance of a translator, where that is necessary) and acknowledge that:

- I have been provided with sufficient information about my/the patient's condition, care options (including the proposed operation/procedure), the risks of the options and any risks that are specific to me/the patient, the benefits of the options, the expected outcome of the proposed operation/procedure and the expected outcome of not undergoing the operation/procedure;
- I have had the opportunity to ask questions about the proposed operation/procedure and to read any information provided and I am satisfied with the information that I have received;
- the operation/procedure involves the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with the proposed operation/procedure;
- if a complication arises during the course of the proposed operation/procedure which requires urgent treatment to save my/the patient's life or prevent serious injury in circumstances where it is not practical to obtain consent, I/the patient will be provided with emergency treatment (which may include blood products) subject to the terms of any prior written and legally valid objection (including my/the patient's direction about the provision of blood below);
- a sample of my/the patient's blood may need to be taken and tested for infectious diseases if there is an injury to a doctor or staff member during the proposed operation/procedure;
- there is a risk that the proposed operation/procedure will not:
  - » for screening procedures: identify the condition being screened for; or
  - » for therapeutic procedures: improve my/the patient's condition or achieve an expected or desired outcome, despite it having been carried out with due professional care and responsibility;
- there are risks associated with the proposed operation/procedure, which may result in a worsening of my/the patient's condition or other adverse outcome for me/the patient and I accept these risks in requesting the proposed operation/procedure;
- images or video footage may be recorded as part of, and during, my/the patient's operation/procedure, and these images or videos will assist the doctor to provide appropriate treatment;
- I have the right to change my mind and withdraw my consent at any time before the operation/procedure, preferably after discussion with my/the patient's doctor.

☑ I consent to the use of anaesthetic or sedation as required to perform the operation/procedure.

☑ I consent to the use of blood products if they are required during my/the patient's operation/procedure.

Signature of Patient or Substitute Decision-Maker

Signature of Patient or Substitute Decision-Maker: | Relationship (if applicable)*: | Date: 03/11/2024

**Relationship between the patient and person who can legally make decisions for the patient (e.g. parent, legal guardian, enduring power of attorney, statutory health attorney or person authorised by law to be a substitute decision-maker as relevant in the state/territory where this form is signed).*

Attach ADR sticker | **Diabetic on insulin**

Allergies and adverse reactions (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Affix patient identification label here and over leaf

UR No

Family name:
Given names:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Address:

DOB:

Sex ☐ **M** ☐ **F**

Medication chart _____ of _____

Weight (kg) _____ Height (cm) _____

IV fluid administration

Date	No	Type of fluid (including strength)	Amount	Time	Additions to flask	Prescriber's signature	Administration				
							Start date	Start time	Finished time	Total infused	RN signature

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (print generic name)	Route	Dose	Date / time of dose	Prescriber / Nurse Initiator (NI) Signature	Prescriber / Nurse Initiator (NI) Print name	Given by	Time given
18/11/2024	G PHENYLEPHRINE 2.5% G. TROPICAMIDE 1% ~~1/2mL Adrenalie 1:1000 in 500mL BSS~~	Right	ONE DROP	30 MINS & 20 MINS	Colby Hart			

Telephone orders (to be signed within 24 hours of order)

Date / time	Medicine (print generic name)	Route	Dose	Frequency	Check initials N1	Check initials N2	Prescriber name	Prescriber signature	Date	Record of administration Time / given by

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Medicines taken prior to presentation to hospital
(Prescriber, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

National Inpatient Medication Chart (NIMC) CMR30

PRIVACY COLLECTION NOTICE - PATIENTS

Cura Day Hospitals Group Pty Ltd (ACN 125 245 409) (Cura) and its subsidiaries acknowledge the importance of patient privacy. We are committed to handling your information securely and to being open and transparent with you about our information handling processes.

Cura's privacy policy is available at www.curagroup.com.au. If you would prefer a printed version, please let us know by contacting us on 07 3218 3700. Further details about how we deal with your personal information are provided below

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Who is collecting your personal information

Your personal information is being collected by Cura Day Hospitals Group Pty Ltd (ACN 125 245 409) (Cura) and its subsidiaries wherever located within Australia.

The contact details for Victoria Parade Surgery Centre are:
Street address: 1 / 100 Victoria Parade, East Melbourne VIC 3002
Telephone: (03) 9650 4000.

Collection of your personal information

Your personal information is collected:

- from you when you provide personal information to us, including by completing admission forms, questionnaires and surveys; when observations are taken; when you report information to our staff about your health; and in some cases by way of photographs taken of you for a clinical purpose;
- from your relatives who may be able to provide us with information relevant to your healthcare where it is unreasonable or impracticable to collect information directly from you;
- from third party health service providers, including your doctors, diagnostic imaging and pathology companies;
- Medicare, DVA and/or your health insurer;
- your My Health Record.

Authority for collection

As a health service provider, we are required to collect and keep medical records of patients receiving services at our facilities.

Why does Cura collect your personal information?

We collect your personal information in order to provide health services to you at our facility. We also use the information for management of our services.

You may be asked to participate in research projects which involve the collection of your personal information. Participation in research is entirely voluntary.

What would happen if Cura did not collect your personal information?

If Cura does not collect your personal information we may not be able to provide healthcare services to you. If we do not collect all of your relevant health information, this may pose a risk to your health as we will be using incomplete information to make care decisions. It may also impact on your ability to claim Medicare, DVA or private health insurance refunds.

Who will Cura disclose your personal information to?

We disclose your health information for the purposes of providing a health service to you and managing that service. For example, we disclose your personal information to other third-party health service providers (e.g. your doctor, relevant clinical registries, pharmacy services, diagnostic imaging and pathology companies) and our staff involved in your care (e.g. nurses and allied health) or providing administrative support. Sometimes your Surgeon will request that a surgical device representative be present during your procedure.

Your Surgeon will ordinarily provide a discharge summary to your referring doctor. Please let your Surgeon know if you do not want this to occur. We may also provide discharge summaries to your treating Surgeon.

	If you have received services at a Cura Hospital as a public patient under an arrangement with either a public hospital or a state or territory government arrangement, we will provide a discharge summary and a copy of your medical record to the public hospital or relevant government entity that referred you. We will disclose information about your condition to your next-of-kin nominated on your admission paperwork if we need a decision to be made about your care and you do not have capacity to make the decision for yourself. We will let your contact person know when you are ready to be collected to go home. We disclose your personal information to Medicare, DVA and your private health insurer for billing and regulatory purposes. We are required to provide certain data to State/Territory Health Departments about admissions to our facilities. We will upload information to My Health Record unless you direct us not to.
Access to and correction of your personal information	Our privacy policy contains information about how you may access and seek correction of personal information about you that Cura holds.
Privacy complaints	Our privacy policy contains information about how you may complain about a breach of the Australian Privacy Principles and how Cura deals with complaints.
Overseas disclosure of your personal information	It is unlikely that Cura will disclose personal information to entities outside of Australia.

Optional additional uses of personal information

Please indicate whether you consent (or not) to us using your information in these additional ways.

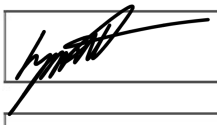
Contacting me to participate in a survey regarding the service I received at a Cura facility	Y ☐	N ☒
Permitting a student to be present during your procedure	Y ☑	N ☐

Is there anyone who you do not want Cura to disclose your information to?

None

Declaration and consent

- I have read and understood the information in this document and consent to the collections, uses and disclosures as described in this document.

Signature	
Name:	Bryan Botterill
Date:	03/11/2024