PROCEDURAL CONSENT

FORM 1

(Patient Label)

I , hereby consent to Endoscopy & Flexible Sigmoidoscopy procedures being performed upon myself:

Initial boxes

a) I have read the information sent to me regarding the procedure(s) and have been adequately informed to have the procedure. I am also aware that for Colonoscopy there is a 1:1000 risk of perforation of the bowel and 1:200-400 chance of bleeding if a polyp is removed. There is also a risk of inhaling stomach contents < 1%. In very rare circumstances a blood transfusion may be required after bleeding from a polypectomy. I understand that should my condition change during the course of my procedure or admission that I will be treated accordingly. ☐

b) I consent to a blood product transfusion ☐ YES ☐ No (please tick). The risks, benefits and alternative treatments have been explained to me and I have received written information. Please bring any relevant documentation. ☐

c) If any staff member is exposed to my (or my child's) blood or other body fluid, then I give my consent to my blood being collected and tested for infectious diseases. I will be informed if this occurs and will be given the results of the tests. ☐

d) If I have an advanced care or end of life directive, it is my responsibility to inform staff at West Coast Endoscopy Centre. (Please ensure you bring this document with you.) ☐

e) I am responsible for any payment not covered by Medicare or my Health Fund and I confirm that checking my health fund entitlement is my responsibility. ☐

f) If my procedure is an "Open Access Booking" i.e. without having a consultation, I acknowledge that I am satisfied with this type of booking and the written explanation I have received. ☐

g) I am aware of my rights and responsibilities. (See attached page) ☐

h) I agree that my medical information will be used in accordance with the privacy act 1988. (Copy of privacy policy available upon request). I am aware that all personal information supplied by me will be confidential and only that which is required to provide any medical service is collected. The collection and handling of this information is within the guidelines of the Privacy Act. (If you wish to view our privacy and/or complaints/compliments information it is available at reception). ☐

i) I accept that because the use of mobile phones are not allowed, my mobile phone will be locked away after I have been admitted and returned to me before I am discharged. I accept that whilst all due care will be taken of mobile phones and valuables, WCEC takes no responsibility for loss/theft or damage if I have brought these with me. ☐

j) Occasionally we have student nurses as part of their nursing training. I consent for them to be present during my admission ☐ YES ☐ No (please tick), supervised by a doctor / health practitioner. ☐

Please tick this box if you consent that we can use your Colonoscopy information and histology for the purpose of audits as required by the GE Society of Australia. ☐

I have read and received the Discharge Plan instructions. If I disregard advice on driving and/or having a responsible adult with me on the day and night of the procedure, I accept full responsibility for failing to follow this advice.

Patient signature: ______________________________ Date : ___________________________

Doctor's Confirmation:
I confirm that the nature, purpose, and risks of this procedure/treatment have been explained to the person who signed the above consent form.

Signed: ______________________________________ Date: _________________________

PROCEDURAL CONSENT

FORM 2

(Patient Label)

Admission Date:		
PATIENT DETAILS		
Title: ☐ Master ☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Other:		
Surname:		
First Name:	Middle Names:	
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other:	
Mobile No:	Home no:	
Address:		
No & Street Name:		
Suburb:	State/ Territory:	Post Code:
Health Insurance		
It is your responsibility to find out from your health care provided whether you are financially covered for this procedure, if you have an excess and if there are any co-payments. When you ring your provider, please ensure to write down the name:_________________________ of the person you spoke to and the date:_______________ of the call.		
Health Fund Name:	Excess: ☐ No ☐ Yes Amount $________	
Membership No:	Date joined:	Title/ Level of cover:
You should check with your health insurance provider to confirm whether your level of insurance covers your required procedure(s) ☐ Colonoscopy #32222 ☐ Endoscopy #30473 ☐ Sigmoidoscopy #32084 ☐ Other:		
Has your waiting period been served? ☐ Yes ☐ No, <u>if no, please contact WCEC</u>		

Anaesthetist and Pathology/ Ambulance Expenses	
Any payments for the anaesthetist and pathology are separate from our accounts. Please phone the anaesthetist's rooms (their details are at the top of the first page) to find out if there are any out-of-pocket fees. If you do not have Medicare/ are a self-insured patient, please phone the anaesthetist and Fremantle Pathology (Tel 9433 3974) to arrange payments before your procedure.	**Initial boxes** ☐
In the unlikely event that you need to be transferred to hospital, an ambulance will be called. If you do not have ambulance cover, this will be at your expense.	☐
West Coast Endoscopy Centre may provide information about the patient to a Credit Reporting Agency, but only limited information as allowed under Section 18E (1) of the Privacy Act 1988 (Commonwealth). The account remains your responsibility should your health fund not pay it. If we have to employ a debt collector to collect any outstanding money, their fees will be added to your account to cover this cost.	☐
<u>FOR HCF PATIENTS ONLY:</u> WCEC does not have a contract with HCF and therefore you will be required to pay a GAP if you are having an Endoscopy (30473).	☐

I, (print full name) ____

(patient/parent/guardian/legal representative)

Have been fully informed of the WCEC fees associated with my/ the patient's admission. I understand and acknowledge that it is my responsibility to confirm with my/ the patient's health insurance fund/insurer the level of cover that I/the patient have/has and any amount that will be my responsibility to pay. I accept full financial responsibility if my health fund does not pay the account. I acknowledge that the anaesthetist and pathology fees are separate to WCEC and the fees associated need to be obtained and discussed with these providers individually. I have been given ample opportunity to ask questions I may have regarding fees changed prior to the commencement of the procedure/treatment. I also understand that in the event of a transfer to another health care service, the expenses and costs associated with that transfer and admission are mine/ the patients and not that of WCEC.

Signature: ______________________________ Date: _________________________