Assessment and Consent for Local Anaesthetic and Associated Treatment

Patient Name DOB

Address GP_____

Type of Procedure Proposed (to be completed by health professional without abbreviations)

Please complete this part of the form

I confirm that I have explained the operation and such options as are available and the type of local anesthetic proposed. I have checked regarding any previous allergies I confirm that I have used terms which in my judgement are suited to the understanding of the patient and/or to the parent or guardian of the patient.

Signature Date_____

Name (Block Capitals) _____

PATIENT/PARENT/GUARDIAN

If there is anything that you don't understand about the explanation, or if you want more information, you should ask the Health Professional who is treating you. If you understand the procedure, and consent to it, then please sign the form below.

I am the patient/parent/guardian (delete as necessary)

I agree to the proposed treatment that has been explained to me by the health professional named on this form.

I understand that:

Any procedure, in addition to the treatment described on this form will only be carried out if necessary and in my best interest and can be justified for clinical reasons.

Patients Name (please print) _____

Patient/parent/guardians signature _____

Patient's signature (if not as above) _____

Date _____