

## Patient consent to examination or treatment

### Executive Summary

The handbook "A guide to consent for examination or treatment" which accompanied HC(90)22 introduced new model forms for obtaining a patient's written consent to examination or treatment.

Following discussion with representatives of the medical profession, the Department has revised the model consent forms at Appendix A and Appendix B of the handbook. This should remove some of the misunderstandings that have arisen since HC(90)22 was introduced.

### Action

NHS Authorities should:

- bring this circular and its enclosures to the attention of all their health professionals;
- introduce revised documentation based on the revised model consent forms enclosed.

### Cancellation of Circulars

Appendices 1 and 2 of the handbook "A Guide to Consent for Examination or Treatment" which accompanied HC(90)22 are cancelled.

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**HSG(92)32**

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Patient consent to  
examination or treatment

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28 July 1992

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#### Addressees

*For action:*  
Regional Health Authorities  
District Health Authorities  
Special Health Authorities for  
the London Postgraduate  
Teaching Hospitals  
Special Hospitals Service  
Authority  
Family Health Services  
Authorities  
NHS Trusts

*For information:*  
Community Health Councils

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# CONSENT FORM

APPENDIX A(1)

## For medical or dental investigation, treatment or operation

Health Authority ..... Patient's Surname .....

Hospital ..... Other Names .....

Unit Number ..... Date of Birth .....

Sex: (please tick)                      Male                       Female

## DOCTORS OR DENTISTS *(This part to be completed by doctor or dentist. See notes on the reverse)*

### Type of operation, investigation or treatment for which written evidence of consent is considered appropriate

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... Date ...../...../.....

Name of doctor or dentist .....

## PATIENT/PARENT/GUARDIAN

1. Please read this form and the notes overleaf very carefully.

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2. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor or dentist.

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3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

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

- I agree  to what is proposed which has been explained to me by the doctor/dentist named on this form.
- to the use of the type of anaesthetic that I have been told about.
- I understand  that the procedure may not be done by the doctor/dentist who has been treating me so far.
- that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- I have told  the doctor or dentist about the procedures listed below I would not wish to be carried out without my having the opportunity to consider them first.

.....  
.....  
.....

Signature .....

Name .....

Address .....

*(if not the patient)* .....

.....

## NOTES TO:

### Doctors, Dentists

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form (further guidance is given in HC(90)22: A Guide to Consent for Examination or Treatment).

### Patients

- The doctor or dentist is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse the treatment.
- You may ask for a relative, or friend, or a nurse to be present.
- Training doctors and dentists and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor or dentist.
- You may, however, decline to be involved in the formal training of medical, dental and other students without this adversely affecting your care and treatment.

# CONSENT FORM

APPENDIX A(2)

## For sterilisation or vasectomy

Health Authority .....  
Hospital .....  
Unit Number .....

Patient's Surname .....  
Other Names .....  
Date of Birth .....  
Sex: (please tick)      Male       Female

### DOCTORS *(This part to be completed by doctor. See notes on the reverse)*

#### Type of operation: Sterilisation or Vasectomy

Complete this part of the form

I confirm that I have explained the procedure and any anaesthetic (general/local) required, to the patient in terms which in my judgement are suited to his/her understanding.

Signature .....      Date ...../...../.....

Name of doctor .....

### PATIENT

1. Please read this form very carefully.
2. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor.
3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient

- I agree  to have this operation, which has been explained to me by the doctor named on this form.
- to have the type of anaesthetic that I have been told about.
- I understand  that the operation may not be done by the doctor who has been treating me.
- that the aim of the operation is to stop me having any children and it might not be possible to reverse the effects of the operation.
- that sterilisation/vasectomy can sometimes fail, and that there is a very small chance that I may become fertile again after some time.
- that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- I have told  the doctor about the procedures listed below I would not wish to be carried out straightaway without my having the opportunity to consider them first.
- .....
- .....
- .....
- For vasectomy  that I may remain fertile or become fertile again after some time.
- I understand  that I will have to use some other contraceptive method until 2 tests in a row show that I am not producing sperm, if I do not want to father any children.

Signature .....

## NOTES TO:

### Doctors

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form (further guidance is given in HC(90)22: A Guide to Consent for Examination or Treatment).

### Patients

- The doctor is here to help you. He or she will explain the proposed procedure, which you are entitled to refuse. You can ask any questions and seek further information.
- You may ask for a relative, or friend, or a nurse to be present.
- Training doctors and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor.
- You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

# CONSENT FORM

APPENDIX A(3)

## For treatment by a health professional other than doctors or dentists

Health Authority .....

Patient's Surname .....

Hospital .....

Other Names .....

Unit Number .....

Date of Birth .....

Sex: (please tick)

Male

Female

### HEALTH PROFESSIONAL *(This part to be completed by health professional. See notes on the reverse)*

### Type of treatment proposed for which written evidence of consent is considered appropriate

Complete this part of the form

I confirm that I have explained the treatment proposed and such appropriate options as are available to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature .....

Date ...../...../.....

Name of health professional .....

Job title of health professional .....

### PATIENT/PARENT/GUARDIAN

1. Please read this form and the notes overleaf very carefully.
2. 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 has explained the treatment proposed.
3. Please check that all the information on the form is correct. If it is, and you understand the treatment proposed, then sign the form.

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

I agree  to what is proposed which has been explained to me by the health professional named on this form.

Signature .....

Name .....

Address .....

*(if not the patient)* .....

.....

## NOTES TO:

### Health Professionals, other than doctors or dentists

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form (further guidance is given in HC(90)22: A Guide to Consent for Examination or Treatment).

### Patients

- The health professional named on this form is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse the treatment.
- You may ask for a relative, or friend, or another member of staff to be present.
- Training doctors, and dentists and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a fully qualified health professional.
- You may however decline to be involved in the formal training of medical, dental and other students without this adversely affecting your care and treatment.

APPENDIX B

Medical or dental treatment of a patient who is unable to consent because of mental disorder

Health Authority ..... Patient's Surname .....
Hospital ..... Other Names .....
Unit Number ..... Date of Birth .....
Sex: (please tick) Male \_\_\_ Female \_\_\_

NOTE:

It is the personal responsibility of any doctor or dentist proposing to treat a patient to determine whether the patient has capacity to give a valid consent.
It is good practice to consult relatives and others who are concerned with the care of the patient. Sometimes consultation with a specialist or specialists will be required.
The form should be signed by the doctor or dentist who carries out the treatment.

DOCTORS/DENTISTS

Describe investigation, operation or treatment proposed.

(Complete this part of the form)

In my opinion ..... is not capable of giving consent to treatment. In my opinion the treatment proposed is in his/her best interests and should be given.

The patient's next of kin have/have not been so informed. (delete as necessary)

Date: .....

Signature: .....

Name of doctor or dentist who is providing treatment:

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