



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

D.O.B. ____ / ____ / ____

M.O.

Facility:

ADDRESS

CONSENT FOR DIALYSIS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Provision of information to patient (To be completed by nephrologist)

I, Dr _____ have discussed with this patient renal replacement therapy for treatment of _____ and recommended

PERITONEAL DIALYSIS / HAEMODIALYSIS (delete where not applicable).

- At the time of this assessment, this patient has capacity to make an informed consent
- I believe this patient is making a voluntary decision
- I am satisfied that this patient has been educated regarding all treatment options, explained risks and benefits as outlined below, checked for understanding, and provided opportunities to ask questions
- Patient information handout has been given to this patient

_____ (signature of nephrologist) _____ (date)

Interpreter _____ (signature) _____ (name)

Patient consent (To be completed by patient)

Dr _____ and I have discussed my present condition and the various ways it might be treated, and recommended **PERITONEAL DIALYSIS / HAEMODIALYSIS**.

The doctor has explained the following aspects of dialysis, including:

- The role and logistics of dialysis treatments
- Benefits and risks of dialysis, including the likely trajectory of my condition with and without dialysis
- Potential complications (delete where not applicable) including vascular access or catheter problems, infection, blood pressure changes, fluid overload, and fatigue after dialysis
- The anticipated effect on my life, and the support I may need now or in the future from my family and carers
- The option and role of conservative care, as an alternative to dialysis

I understand the information above, and have been given opportunities to ask questions.

I request and consent to PERITONEAL DIALYSIS / HAEMODIALYSIS.

I am making this decision voluntarily, and understand I can withdraw consent at any time.

_____ (signature of patient) _____ (date)

_____ (print name of patient)

CONSENT FOR DIALYSIS

SES020.033



SES020033

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

NHSIS1014 24117

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

CONSENT FOR DIALYSIS

Consent by surrogate decision maker (To be completed by person responsible or enduring guardian)

Name _____

Relationship to patient _____

_____ (patient name) lacks sufficient decision making capacity regarding dialysis. I have understood the information outlined above, and am acting in the best interest of the patient. I consent to **PERITONEAL DIALYSIS / HAEMODIALYSIS** on his / her behalf.

_____ (signature of surrogate decision maker) _____ (date)

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