Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CONSENT FOR DIALYSIS

SES020033

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)

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

CONSENT FOR DIALYSIS

SES020.033

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