Important note:
To be completed and attached to the consent form Patient agreement to investigation or treatment.
Supplementary Consent Form

Consultant or other health professional responsible for your care

Name and job title: .......................................................................................................................

☐ Special requirements
   (For example, other language/other communication method)

I ........................................................................................................................................

of ........................................................................................................................................

hereby give my consent to the performance upon me of the operation/procedure of

The nature and purpose of which have been explained to me by

Dr / Mr ..................................................................................................................................

and to the administration of general, local or other anaesthetic. I also give my consent to the
performance upon me of any other operative procedure which in the opinion of the surgeon it may be
necessary to perform upon me, without having obtained my express consent, during or by reason of the
said operation/procedure or anything connected with it; except that, although it has been explained to
me that in the course of or by reason of the said operation/procedure it may be necessary to give me
a blood transfusion (red cells, white cells, plasma or platelets) so as to render the operation/procedure
successful, or to prevent injury to my health, or even to preserve my life.

I hereby expressly withhold my consent to and forbid the administration to me of a blood transfusion in
any circumstances or for any reason whatsoever and I accordingly absolve the surgeon, the hospital and
every member of the medical staff concerned from all responsibility, and from any liability to me, or to
my estate, or to my dependants, for any damage or injury which may be caused to me, or to my estate
or to my dependants, in any way arising out of or connected with this my refusal to consent to any such
blood transfusion.

I understand that you cannot give me a guarantee that a particular person will perform the operation/
procedure. The person will, however, have appropriate experience.

Signed (patient): .................................................................................................................

Date: R.R./M.M./Y.Y.Y.Y

Witness to Patient's Signature (signed): ..................................................................................

Date: R.R./M.M./Y.Y.Y.Y

Name of witness (PRINT): ..................................................................................................

Address: .................................................................................................................................

(Witness present at interview)

Signed (Health professional): .................................................................................................

Date: R.R./M.M./Y.Y.Y.Y

Name (PRINT): ....................................................................................................................

Time (24hr): H.H.: M.M.

Designation: ...........................................................................................................................

Contact/bleep no: ....................................................................................................................

Note: please ensure this is attached to the patient’s consent to the investigation or treatment.