

NEO-NATAL CIRCUMCISION PATIENT REGISTRATION

Please fill out and circle relevant information

Baby's Family Name: **First Name:**

Date of birth:/...../..... **Weight:**kg

Address: **No** **Street**..... **Suburb**..... **P/C**.....

Telephone: **(Home)**..... **(Mobile)**

Medicare No: **Ref No:** **Expiry:**/.....

Reason for Circumcision: Religion / Family Tradition / Health / Other.....

Any Bleeding Disorders in Family? Yes / No

Family GP Name

 Clinic Name

 Address.....

How did you find us: Recommended by a friend / Ad in local paper / Yellow pages / White Pages / Internet /GP referral / Maternal Health Nurse / Hospital /Other.....

CONSENT TO CIRCUMCISION

Parent/Guardian Name: **Date of birth**...../...../.....

I consent to the administration of local anaesthetic to my baby and the operation of circumcision.
I acknowledge that this procedure has the following risks all of which may require further medical and/or hospital intervention:-

1. Post-operative bleeding
2. Infection ranging from mild to severe sepsis
3. Buried or trapped penis
4. Insufficient foreskin removal
5. Meatal stenosis (narrowing of the urethral opening)
6. Trauma to the head or shaft of the penis
7. Adverse reactions to the skin preparation
8. Risks of the local anaesthetic including bruising, pain during the procedure from ineffective placement, respiratory or cardiac arrest, and fitting
9. Acute urinary retention

I acknowledge that I have been given printed information, explanation and counselling prior to the circumcision being performed.
I acknowledge that my baby's medical record will be held in a secure electronic &/or hard copy form and the practice may use electronic transmissions in the management of my medical record and care. I understand that the record will only be accessed by approved users during the course of their work. I also acknowledge that I maybe sent reminder/recall letters as part of this practice's preventive health measures. The practice is an accredited teaching practice for undergraduates and postgraduates. I acknowledge that I may decline their presence during a consultation. The practice also participates in clinical research, accreditation and quality assurance activities that may require access to records by approved users. The practice undertakes to not use any information that would identify your health record individually without your consent except where legally required or requested with your consent including transfer or copying medical records. Please ask staff for information on how to access records from your previous surgery. The practice conforms to the requirements of Privacy Legislation and the practice policy on privacy is available for perusal on request from Reception

Signed _____ Date _____

Office use only:

Information sheets	Y / N	Marcaine amount	ml
Post op sheets	Y / N	Trimmer Size	1.1 / 1.3
Explanation &Counselling	Y / N	Operation routine	Y / N
Load No.	/		
Letter Sent	Y / N	Follow up Call	Y / N