CONSENT FOR ANTENATAL BLOODS

Information leaflet(s) on antenatal blood tests given: □

Initials ____________ Date ____________

Consent to Antenatal Blood Tests
I hereby consent to have a blood sample taken from me for:

<table>
<thead>
<tr>
<th>Test</th>
<th>Please tick</th>
<th>Please tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBC - Haemoglobin / Platelets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibody screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VDRL &amp; TPHA (syphilis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Antibody test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemoglobinopathy screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand these tests are required so that appropriate treatment can be given to me and/or my baby. The reason for each of the individual tests being performed on my blood has been explained to me by Doctor/Midwife:

Patient / Service User Signature: ___________________________ Date: ____________

Signature of Guardian (if appropriate): ___________________________ Date: ____________

Relationship to patient / service user: ___________________________

Witnessed by: Doctor/Midwife:

<table>
<thead>
<tr>
<th>Signature</th>
<th>PRINTED NAME</th>
<th>Job Title / Bleep / Identification No.</th>
<th>Date</th>
<th>Time (24 hour)</th>
</tr>
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I do not consent to having a blood sample taken from me for the following tests:

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This is to certify that I, the undersigned, insist on taking

(a) my own   ☐

(b) my baby’s  ☐

dischARGE AGAINST MEDICAL ADVice FROM HOSPITAL

discharge from hospital contrary to medical advice and against the wishes of the hospital staff. The potential consequences of this action have been explained to me and I take responsibility for my actions.

Patient / Service User Signature: ___________________________ Date: __________

Signature of Guardian (if appropriate): ___________________________ Date: __________

Relationship to patient / service user: ______________________________________

Witnessed by: Doctor/Midwife:

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Patient / Service User Signature: ___________________________ Date: __________

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Relationship to patient / service user: ______________________________________

Witnessed by: Doctor/Midwife:

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Please affix woman’s ID label here

Labels should contain the following information:
  - Name
  - Address
  - Date of Birth
  - Healthcare Record Number
DISCHARGE AGAINST MEDICAL ADVICE FROM HOSPITAL

This is to certify that I, the undersigned, insist on taking

(a) my own ☐  
(b) my baby’s ☐

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Patient / Service User Signature: ____________________________ Date: __________

Signature of Guardian (if appropriate): ____________________________ Date: __________

Relationship to patient / service user: __________________________

Witnessed by: Doctor/Midwife:

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CONSENT FOR ANAESTHESIA

Please tick (√)

Epidural   
Spinal     
Intrathecal

I,

of,

understand that

- Pressure associated with the baby’s head progressing downwards will not be eliminated
- I may require an oxytocin infusion, which is an intravenous treatment that makes the uterus contract more strongly
- I may not feel like pushing just before the birth and the anaesthesia may need to be turned down in the second stage of labour
- Back pain after childbirth is common, it also occurs in women who do not have this procedure.

I am aware of the following possible risks of having this procedure

- Possible technical difficulties:
  - with the insertion
  - unequal, patchy or failed blocks
- There may be failure to relieve pain or inadequate pain relief
- Common 'benign' side-effects:
  - shivering
  - heaviness or tingling in the legs
  - difficulty in passing urine, for which I may need a catheter (tube) in the bladder
  - temporary nausea and vomiting
- Common more serious side-effects:
  - hypotension (low blood pressure) usually prevented by intravenous fluids and avoiding aorto-caval compression
- Rare but potentially serious complications:
  - dural tap and post dural puncture headache which may require further treatment
  - development of infection, requiring treatment with antibiotics
  - intravascular injection
  - high block
  - neurological damage e.g. numbness and/or weakness of thigh, leg or foot (usually gets better)
  - rapid absorption of local anaesthetics causing dizziness and seizures
  - temporary total spinal anaesthesia (requiring life support systems)
  - respiratory and/or cardiac arrest (requiring life support systems)
  - breakage of needles, catheters, etc. possibly requiring surgery
- My baby’s condition may change as a result of one of the above complications, which may require vacuum, forceps, or caesarean birth
**CONSENT FOR ANAESTHESIA (CONTINUED)**

**PATIENT / SERVICE USER’S DECLARATION**

My signature below means that:

I have read and understand this consent form

- If English is not my first language, an interpreter and / or translation services were offered and provided to me: Yes [ ] No [ ] N/A [ ]
- I have been given all the information I asked for about the procedure, risks and other options
- I hereby give my consent and authorisation to perform the procedure and to the administration of drugs in this way to provide pain relief during my labour
- I understand that this consent may be withdrawn by me at any time.

Patient / Service User Signature: ____________________________ Date: ______________

Signature of Guardian: ____________________________ Date: ______________

(if appropriate)

Relationship to patient / service user: ____________________________

**DOCTOR’S DECLARATION**

- I have explained the nature and consequences of the pain relief to be administered, and discussed the risks that particularly concern the patient / service user
- I have given the patient / service user an opportunity to ask questions and I have answered these
- I witnessed the above signatures

Signature PRINTED NAME Job Title / Bleep / Identification No. Date Time (24 hour)

**INTERPRETER’S DECLARATION (to be completed if Interpreter present in person)**

- I confirm I have accurately interpreted the contents of this form and the related conversations between the patient / service user and the doctor.

Signature PRINTED NAME Job Title / Bleep / Identification No. Date Time (24 hour)