Workers Compensation Waiver Form

Read every section before signing. Ask your clinician to explain anything that is unclear, and keep a copy of the signed form for your records.

Name: _____ **Date completed:** _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy **Record / MRN number:** _____

Procedure or service: Workers Compensation:

Proposed date: _____ dd / mm / yyyy **Clinician responsible:** _____

1. WHAT IS BEING PROPOSED

Your clinician will describe what the Workers Compensation procedure involves, how long it is expected to take and what you will notice afterwards.

Description discussed

2. BENEFITS AND EXPECTED OUTCOME

No outcome can be guaranteed. The benefits discussed with you are recorded here.

Benefits discussed

3. RISKS AND SIDE EFFECTS

Confirm that each of the following has been explained to you.

Risks and side effects confirmed

- [ ] Common side effects and how long they usually last
- [ ] Uncommon but serious risks specific to this procedure
- [ ] What to do, and who to contact, if a complication occurs
- [ ] The likely recovery period and any activity restrictions

Additional risks specific to me

4. ALTERNATIVES

Alternatives confirmed

- [ ] Alternative treatments have been explained to me
- [ ] The option of having no treatment has been explained to me
- [ ] I have had the opportunity to ask questions and they were answered

5. PHOTOGRAPHY

I agree to clinical photographs being taken for my records.

◯ Yes ◯ No

I agree to anonymised photographs being used for teaching or marketing.

◯ Yes ◯ No

6. RELEVANT MEDICAL HISTORY, MEDICATION AND ALLERGIES

6. Relevant medical history, medication and allergies

I confirm that I have read and understood this form. I have had the procedure, its risks, its benefits and the alternatives explained to me in language I understand.

I understand that I may withdraw my consent at any time before the procedure begins, and that no guarantee has been given about the result.

SIGNATURES

Patient signature and date
Complete only where the patient is under 18 or lacks capacity to consent.

Clinician signature and date

Parent / guardian signature and date
Relationship to patient: _____