

Consent Record

Document control | CON-FRM-001 | New; based on SOP-118

Field	Content
Title	Consent Record
Document ID	{{facility.code}}-CON-FRM-001
Version and status	1.0 Approved by the ASF Expert Committee
Prepared by	{{roles.quality_lead.name}}, Quality lead
Reviewed by	{{roles.clinical_director.name}}, Clinical director date: _____
Approver and signature	{{roles.clinical_director.name}}, clinical director Signature: _____ Date: _____
Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months after effective date)
Supersedes	None (new document)
Standards and criteria supported	Standard 1, criterion 1.3
Evidence basis	E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

1. Purpose

To record informed consent for significant care, one record per procedure.

2. How to use

Complete one form per patient, per area or per period, as the purpose states. Tick Yes, No or N/A. Any No is actioned at once and reported to the person named in the procedure.

3. Items

#	Item to check	Standard [evidence]	Yes	No	N/A	Action if No
1	Procedure, risks and alternatives explained	Yes [EC]	☐	☐	☐	Action and who to tell
2	Interpreter used if needed	Yes or N/A [EC]	☐	☐	☐	Action and who to tell
3	Capacity confirmed or legal representative named	Yes [EC]	☐	☐	☐	Action and who to tell
4	Patient signed or verbal consent recorded with witness	Yes [EC]	☐	☐	☐	Action and who to tell
5	Consent recorded before the procedure	Yes [EC]	☐	☐	☐	Action and who to tell

Completed by (name and role): _____ Date/time: _____ Signature: _____

Retention: {{facility.records_retention_years}} years, filed as set in the retention schedule (REC-POL-001).

4. Evidence

ID	Source	Link / status
E-009	ASF Expert Committee consensus.	see source

EC = ASF Expert Committee consensus.