

Guideline for Qualified Professionals Providing Clinical Context to Support Completion of ASUM Teaching Ultrasound Consent Forms

Approved by the ASUM Board of Directors, October 2026

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1. Purpose and Scope

These guidelines assist qualified sonographers or healthcare professionals working within their scope of practice or a medical practitioner who is specifically trained to perform the ultrasound examination (**Qualified Professionals**) when obtaining informed consent from patient volunteers (**Patient Volunteers**) for ultrasound examinations undertaken for teaching purposes.

They apply to the following ASUM consent forms

- Consent to Intrusive (Internal) Ultrasound Scanning for Teaching Purposes
- Consent to General and Pregnancy Ultrasound Scanning for Teaching Purposes
- Consent to External Ultrasound Scanning of Minors for Teaching Purposes

These guidelines are not a substitute for and do not replace each **Qualified Professional's** clinical judgement or a proper understanding, consideration and discharge of the **Qualified Professional's** professional standards and legal obligations.

Notwithstanding the guidance contained in this document, a **Qualified Professional** seeking informed consent must exercise skill and professional judgement consistent with their scope of practice, discharge their professional duties, and act in accordance with applicable professional standards and legal obligations.

This Guideline does not constitute legal advice.

2. Underpinning Standards and Legislative Framework

2.1 ASUM Standards and Guidelines

The three consent forms are approved ASUM documents, which were reviewed and updated most recently in June 2026

When seeking informed consent for ultrasound examinations conducted for teaching purposes, the **Qualified Professional** **must** provide the **Patient Volunteer** with **ASUM's Guideline for Patient Volunteers** as part of the consent process and before it is given.

Reference Current versions of all ASUM standards and guidelines are available at www.asum.com.au. **Qualified Professionals** should ensure they are referring to the most recent versions.

2.2 National Safety and Quality Standards

Australia — NSQHS Standards

The process to be used when completing any of the three ASUM consent forms is explicitly linked to the NSQHS Informed Consent Fact Sheet (ACSQHC, Standard 2 Action 2.04)

[*Informed consent - practical guidance for clinicians | Australian Commission on Safety and Quality in Health Care*](#)

[*National Safety and Quality Health Service Standards | Australian Commission on Safety and Quality in Health Care*](#)

[*Partnering with Consumers Standard | Australian Commission on Safety and Quality in Health Care*](#)

Qualified Professionals must comply with all legislative requirements when delivering ultrasound education in Australia. The following instruments are provided as guidance at the time of writing this document:

- Provide the **Patient Volunteer** with the ACSQHC informed consent fact sheet ([Microsoft Word - Final for Briefing - Fact Sheet - Informed Consent - Practical guidance for patients.DOCX](#)) prior to or during the consent discussion.
- Ensure the consent process meets the requirements of NSQHS Standard 2 as it pertains to shared decision-making.
- Document that the fact sheet was provided.

New Zealand — Health Quality & Safety Commission

Qualified Professionals must comply with all legislative requirements when delivering ultrasound training in New Zealand. The following instruments, are provided as guidance at time of writing this document:

- Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 1996 (the Code): Right 6 (Right to be Fully Informed), Right 7 (Right to Make an Informed Choice and Give Informed Consent) , Right 8 (Right to Support), Right 9 (Rights in Respect of Teaching or Research) and Right 10 (Right to Complain) are directly applicable to the consent process for teaching ultrasound examinations. Right 9 expressly provides that all rights in the Code, including Rights 1 to 8 and Right 10, extend to occasions where a consumer is participating, or it is proposed that a consumer participate, in teaching. Qualified Professionals must ensure that the consent discussion complies with these Rights.
- Health and Disability Commissioner Act 1994: establishes the HDC and the Code; **Qualified Professionals** should be aware of the complaint processes and professional accountability under this Act.
- [*Health and Disability Services \(Safety\) Standards Notice 2021 | New Zealand Legislation*](#)
- [*https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/services-standard/training-and-support*](https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/services-standard/training-and-support)

- [Clinical governance framework | Health Quality & Safety Commission Te Tāhū Hauora](#)
- <https://www.healthnz.govt.nz/privacy/informed-consent>

NZ Note The NSQHS Informed Consent Fact Sheet referenced in the ASUM consent forms is an Australian document. **Qualified Professionals** should supplement this with reference to the HDC Code Right 6 and Right 7 information sheets, available at www.hdc.org.nz.

2.3 Australian Legislative Framework

Qualified Professionals must understand and be familiar with legislative instruments as they bear on consent to medical procedures. The following are provided as guidance at the time of writing this document.

- The regulatory framework established by the Health Practitioner Regulation National Law (**National Law**) (as in force in each State/Territory under relevant legislation and the National Registration and Accreditation Scheme (**National Scheme**)). The National Law governs registration requirements and scope of practice for registered health practitioners. The National Scheme is co-ordinated by The Australian Health Practitioner Regulation Agency and, amongst other things, sets national health practitioner standards.
- *Privacy Act 1988* (Cth) and Australian Privacy Principles: relevant to recording, storage and de-identification of ultrasound images and data obtained during teaching sessions.
- Relevant state/territory consent to medical treatment legislation (e.g., Consent to Medical Treatment and Palliative Care Act 1995 (SA), Medical Treatment Planning and Decisions Act 2016 (Vic)): governs capacity, substituted decision-making, and the age of consent.

2.4 New Zealand Legislative Framework

Qualified Professionals must understand and be familiar with legislation that bears on consent to medical procedures and health practitioner regulation. The following are provided as guidance at the time of writing this document:

- *Health Practitioners Competence Assurance Act 2003* (HPCAA): governs the registration and scope of practice of health practitioners in New Zealand, including sonographers registered under the Medical Radiation Technologists Board and medical practitioners registered under the Medical Council of New Zealand. **Qualified Professionals** must act within their scope of practice as defined by the relevant responsible authority. Sonographers (including those performing teaching ultrasound examinations) performing teaching ultrasound examinations must hold current registration and an annual practising certificate from the MRTB.
- *Health Information Privacy Code 2020* (issued under the Privacy Act 2020): governs the collection, use, storage and disclosure of health information in New Zealand, including ultrasound images and recordings obtained during teaching sessions.
- *Privacy Act 2020* (NZ): the overarching privacy framework; relevant to recording, de-identification and storage of Patient Volunteer data and images.

- Code of Health and Disability Services Consumers' Rights **1996 (HDC Code)**: as noted in Section 2.2, Rights 6 and 7 directly govern informed consent obligations.
- *Age of Majority Act 1970 (NZ)*: sets the general age of majority (full legal capacity) in New Zealand at 20 years. This Act does not itself govern consent to medical treatment or procedures, which is instead addressed by section 36 of the Care of Children Act 2004 (see below). "Minor" for the purposes of general legal capacity in New Zealand therefore means a person under 20 years, but a materially different (lower) age threshold of 16 years applies specifically to medical consent.
- *Care of Children Act 2004 (NZ)*: governs parental responsibility and guardianship; relevant to identifying who is authorised to consent on behalf of a minor. Under section 36 of this Act, a young person aged 16 years or over may give (or refuse) their own legally effective consent to a medical, surgical or dental procedure, including participation in a teaching ultrasound examination, as if they were of full age. Guardians may consent on behalf of a child under 16 who is unable to consent, but the fact that a child is under 16 does not of itself mean they lack capacity to consent. New Zealand courts have recognised that a child or young person under 16 with sufficient decision-making skills or mental capacity may give valid and effective consent to their own medical treatment (applying a Gillick-type competence assessment). **Qualified Professionals** must treat a Patient Volunteer aged 16 to 19 years as capable of giving their own consent in place of, or in addition to, guardian consent, unless there are reasonable grounds to believe the young person lacks the competence to do so.

2.5 Child Safe Practices and Legislation

Where the **Patient Volunteer** is a minor (under 18 years of age in Australia or under 16 years of age in New Zealand for the purposes of independent medical consent under section 36 of the Care of Children Act 2004), the following additional framework applies and must be observed:

Australian National Child Safe Framework

- The National Principles for Child Safe Organisations (Australian Human Rights Commission, 2019): **Qualified Professionals** involved in teaching sessions with minors should be familiar with Principles 3, 4 and 6, which concern child-safe environments, culturally safe practices, and equity for Aboriginal and Torres Strait Islander children.
- National Child Safety Legislation: each state and territory has enacted child safety legislation that imposes obligations on organisations and individuals working with children. **Qualified Professionals** must be aware of and compliant with the legislation in the jurisdiction in which the teaching activity occurs.

Relevant State and Territory Instruments (Australia)

- Children and Young Persons (Care and Protection) Act 1998 (NSW)
- Child Wellbeing and Safety Act 2005 (Vic)
- Child Protection Act 1999 (Qld)
- Children and Young People Act 2008 (ACT)
- Children and Young People (Safety) Act 2017 (SA)
- Children and Young People Act 2023 (Tas)

- Children and Young People Act 2008 (WA) — noting the Child Protection (Working with Children) Act 2012
- Care and Protection of Children Act 2007 (NT)

Note **Qualified Professionals** must hold current Working with Children clearances (or jurisdictional equivalent) where required by law and institutional policy.

New Zealand Child Safe Framework

New Zealand has enacted its own comprehensive child protection framework. **Qualified Professionals** involved in the **Teaching Event** at which minors participate must be familiar with and comply with the following:

- Oranga Tamariki Act 1989 (Children, Young Persons, and Their Families Act): the principal child protection statute in New Zealand. Establishes the welfare and best interests of the child as the paramount consideration. Any person, including **Qualified Professionals**, who believes a child or young person has been, or is likely to be, harmed, ill-treated, abused, neglected or deprived, or who has concerns about a child's wellbeing, may report the matter to Oranga Tamariki or the Police. Reports made in good faith attract protection from civil, criminal or disciplinary proceedings. **Qualified Professionals** should also have regard to any mandatory reporting obligations that may separately apply to them under their profession's code of conduct or their employer's or the Event Organiser's policies.
- Children's Act 2014 (NZ): establishes the children's workforce safety-checking regime. **Qualified Professionals** who work with children in a regulated work context (which may include organised educational events involving minors) must hold a current Police vet and, where applicable, a children's worker safety check, updated at least every three years. Organising institutions are responsible for determining whether the regime applies and ensuring compliance.
- Education and Training Act 2020 (NZ): relevant where **Teaching Events** occur in educational settings.
- Child Protection Policy requirements: under the Children's Act 2014, organisations that work with children must have a written child protection policy. **Qualified Professionals** should confirm that the organising institution has such a policy and that the **Teaching Event** is conducted within its terms.

NZ Note New Zealand does not have a single national 'Working with Children Check' equivalent to the Australian state-based schemes. The children's workforce safety-checking regime under the Children's Act 2014 applies to regulated work with children. **Qualified Professionals** should confirm current obligations with their employer or the **Event Organiser**.

Additional Child Safe Considerations

Te Tiriti o Waitangi / Treaty of Waitangi (New Zealand)

Qualified Professionals must give effect to the principles of Te Tiriti o Waitangi in their clinical practice and in the conduct of teaching activities. This includes:

- Recognising the particular obligations owed to Māori tamariki (children) and their whanau (families) under Te Tiriti, and ensuring that consent processes are conducted in a culturally safe and responsive manner.
- Applying the principles of the HDC Code in a manner consistent with the Treaty, including respect for the mana (dignity and authority) of Māori **Patient Volunteers** and their families.
- Being aware that the Pae Ora (Healthy Futures) Act 2022 places obligations on the health system to achieve health equity for Māori, which informs how **Qualified Professionals** approach participation and consent in teaching settings.

Gillick Competence (Australia)

The Consent to External Ultrasound Scanning of Minors for Teaching Purposes specifically refers to the Gillick competence level. **Qualified Professionals** must:

- Assess whether the minor child is present and of sufficient age, cognition and maturity to understand the information disclosed as part of the consent process.
- Not proceed on the basis of guardian consent alone if the minor does not demonstrate understanding or assent, or if the minor objects, resists or appears distressed.
- Understand that Gillick competence is a clinical and legal assessment, not a fixed age threshold. When in doubt, seek guidance from the organising institution's ethics or legal team.

Note

Where the **Qualified Professional** who provides information and the clinical context differs from the **Qualified Professional** who ultimately performs the examination, both must be documented on the consent form for all scanning of minors.

Records must be retained in accordance with the organisation's child safety policies and all applicable legislative requirements.

Note

The **ASUM Consent to Ultrasound Scanning of Minors for Teaching Purposes** consent form applies to external examinations only. There is an absolute prohibition on internal (intimate) ultrasound examination of a minor child for teaching purposes when consent is provided via this form. This requirement is non-negotiable and cannot be overridden by guardian consent, institutional policy or clinical justification within a teaching context.

3. Providing Clinical Context: General Obligations

3.1 Who May Provide Clinical Context

Only a **Qualified Professional** may provide information and clinical context as part of seeking informed consent from **Patient Volunteers**. A **Qualified Professional** is either:

- A qualified sonographer working within their scope of practice as defined by the Australian Sonographer Accreditation Registry (ASAR) (Australia) or the Medical Radiation Technologists Board (MRTB) (New Zealand);
- A qualified healthcare professional trained to perform the type of ultrasound examination covered by the consent form or;
- A medical practitioner specifically trained to perform the type of ultrasound examination covered by the consent form.

The provision of information and clinical context when seeking informed consent is not delegable to administrative, non-clinical staff.

3.2 Core Content of Clinical Context

When completing the **Qualified Professional** confirmation section of each consent form, the **Qualified Professional** must be able to attest that they have addressed all of the following elements. These mirror the checklist items on each form:

Element	Key Points for Qualified Professionals
Nature, purpose and process of the examination	Explain what will occur, using plain language. Describe transducer use, gel application, and (where applicable) internal/external scanning. Specify that the examination is for teaching, not diagnosis.
Non-diagnostic nature	Clearly state that the scan will not provide diagnostic information to the Patient Volunteer or their treating clinician. Patient Volunteers can be directed to see their GP or specialist.
Risks and anticipated discomfort	Discuss physical discomfort (pressure, gel temperature, probe insertion for internal). Note that risk of injury is small but present. Invite disclosure of health problems or allergies that may affect safety.
Persons present / privacy arrangements	Advise the approximate number of observers and trainees. Describe privacy screens. Confirm whether images will be projected or recorded. Confirm identity protection measures.

Right to support person	Explicitly advise the Patient Volunteer that they may have a support person present. For minors, an appropriate support person must be present.
Voluntary participation and right to withdraw	Confirm participation is voluntary, without consequence. Explain that consent may be withdrawn at any time by explicit verbal request to the performing Qualified Professional.
Questions and understanding	Allow adequate time for questions. Answer to the best of your ability. Verify comprehension — do not simply ask 'Do you understand?'; use open-ended questions or teach-back.

3.3 Language and Communication

- Use plain, non-technical language appropriate to the **Patient Volunteer's** level of health literacy.
- Where the **Patient Volunteer's** primary language is not English, a professional interpreter should be arranged. Do not rely on family members to interpret.
- For **Patient Volunteers** with cognitive or communication disabilities, adapt the explanation accordingly and document any additional measures taken.
- Avoid leading questions when verifying understanding; use open-ended or teach-back methods.

3.4 Timing of Consent

Consent must not be obtained under time pressure or immediately prior to the commencement of a **Teaching Event** where the **Patient Volunteer** has no real opportunity to consider the information or clinical context. ASUM's requirements, consistent with NSQHS Standard2, mean that:

- Clinical context should be provided sufficiently in advance of the examination for the **Patient Volunteer** to ask questions and make a considered decision.
- A signed consent form does not relieve the **Qualified Professional** of the duty to confirm willingness to participate before and during the ultrasound examination.

4. Reading Patient Volunteer Cues

Obtaining a signed consent form is not the endpoint of the consent process. Consent is ongoing and dynamic. A **Patient Volunteer** may have willingly signed a consent form but become uncomfortable, distressed, or uncertain during the examination. **Qualified Professionals** have an active duty to remain alert to cues that a **Patient Volunteer's** willingness has changed, and to respond immediately and appropriately when those cues are observed.

This duty applies throughout the consent discussion, during the examination, and in the moments immediately following. It cannot be delegated to a chaperone or support person, and it is not discharged by the existence of a signed form.

4.1 Verbal Cues

The most direct cues are spoken ones. **Qualified Professionals** must respond immediately to any verbal expression of discomfort, reluctance or withdrawal, including expressions that are indirect, tentative or framed as questions. Do not wait for an explicit request to stop before acting.

Verbal cues warranting an immediate pause or cessation include:

- Direct requests to stop or pause: "Stop", "Wait", "I need a moment", "Can we take a break?"
- Expressions of pain or physical discomfort: "That hurts", "That's really uncomfortable", "Ow"
- Expressions of emotional distress: "I'm not sure about this", "I feel a bit overwhelmed", "I don't think I want to do this anymore"
- Withdrawing previously given information: "Actually, I didn't realise it would be like this"
- Questions about stopping: "Can I stop now?", "Do I have to keep going?"
- Hedged or minimised discomfort: "It's fine, I suppose" or "I'm okay" stated in a tone inconsistent with the words: follow up directly

Practice point	When a Patient Volunteer says something ambiguous, pause and check in directly: "I want to make sure you're comfortable to continue, are you happy to go on?" Never reframe a hesitant or ambiguous response as agreement.
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4.2 Non-Verbal Cues

Many **Patient Volunteers**, particularly those who are anxious, have experienced trauma, are from cultures where deference to authority is expected, or who are concerned about disrupting a **Teaching Event**, will not verbalise distress even when it is present. **Qualified Professionals** must look and respond to non-verbal indicators, which may be the only signals available.

Physical cues

- Muscle tension, rigidity or bracing of the body, particularly relevant during intimate examinations
- Flinching, withdrawing or pulling away from contact
- Gripping clothing, bedding or the examination table
- Shallow, rapid or held breathing or a marked change in breathing pattern
- Pallor, flushing, sweating or trembling
- Closed body posture, for example, crossed arms, legs pressed together, turning the body away
- Averting the eyes, looking toward the exit, or scanning the room

Facial cues

- Grimacing, lip-biting, or clenching of the jaw
- Tearfulness or eyes welling up
- Blank or dissociated expression, for example, the absence of normal facial responsiveness
- Forced or strained smile inconsistent with other body language

Behavioural cues

- Going very quiet after previously engaging, for example, sudden withdrawal from conversation
- Not responding to questions or responding with minimal monosyllables
- Repeatedly looking at a support person, guardian or chaperone as if seeking permission or reassurance
- Compliance that appears automatic or 'frozen' rather than active and engaged. This is particularly important in intimate examinations and with minors

Trauma-informed practice	Freezing or passive compliance is a recognised trauma response and must not be interpreted as consent or comfort. If a Patient Volunteer appears to have disengaged, withdrawn, or 'gone still', stop the examination, address the Patient Volunteer directly by name, and check their wellbeing before considering whether to continue.
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4.3 Cues Specific to Children and Young People

Children and young people may not have the vocabulary, authority or confidence to verbalise distress in front of adults they perceive as having authority. **Qualified Professionals** working with minors must apply a heightened level of attentiveness to non-verbal cues and must be willing to stop the examination on the basis of observation alone, without waiting for a verbal request.

- Watch for changes in facial expression, body language or engagement that suggest the child has become uncomfortable, even if they continue to comply.
- A child who was chatty or engaged during the consent discussion but becomes silent, still or blank during the examination should be treated as showing a withdrawal cue.
- If the guardian or support person appears uncomfortable, distressed or is signalling concern — verbally or non-verbally, treat this as a cue to pause and check in.
- Do not interpret a child's continued stillness as cooperation. Ask them directly, in age-appropriate language: "Is it okay to keep going?" or "Are you alright?"
- Be aware that children may look to their parent or guardian for cues about how to respond, if the child's response appears shaped by the adult's presence rather than their own feelings, create space for the child to respond without the adult answering for them.

4.4 Cues During Intimate Examinations

The intimate nature of transvaginal and transrectal examinations means that the physical and psychological threshold for distress is lower, and the potential impact of not responding to cues is significantly greater. **Qualified Professionals** must apply the highest level of attentiveness to **Patient Volunteer** cues throughout intimate examinations.

- Check in verbally with the **Patient Volunteer** at each stage of an intimate examination — before probe insertion, during, and before any change of probe position or technique.
- Do not interpret absence of protest as comfort. Actively invite the **Patient Volunteer** to communicate: "Let me know at any point if you want me to stop or if anything is uncomfortable."

- Any physical resistance, including involuntary muscle contraction, pulling away, or leg closure, must result in an immediate pause, regardless of whether the **Patient Volunteer** verbalises a request to stop.
- Pay particular attention to changes in the **Patient Volunteer's** breathing, grip or facial expression during insertion or probe movement.
- If a **Patient Volunteer's** engagement decreases or their responses become delayed or monosyllabic during the examination, pause and check in directly before continuing.

4.5 Cues During the Consent Discussion

Patient Volunteer cues are not limited to the examination itself. The consent discussion is also a setting in which uncertainty, pressure and distress may arise. **Qualified Professionals** should observe for:

- Hesitation before signing, or repeated reading of sections of the form, which may indicate unresolved questions or concerns the **Patient Volunteer** has not felt able to voice.
- Signing without reading, this may indicate the **Patient Volunteer** does not feel empowered to ask for time, or does not feel able to refuse.
- Deferral to a companion, for example, if the **Patient Volunteer** consistently looks to a support person, family member or companion before answering questions or making decisions, check that the consent being given is the **Patient Volunteer's** own.
- Signs of anxiety, for example, rapid speech, nervous laughter, inability to maintain focus, or physical signs of anxiety (fidgeting, avoiding eye contact) during the explanation.
- Apparent language or comprehension difficulty for example, if the **Patient Volunteer** appears not to be understanding the explanation, do not proceed until you are confident comprehension has been established, with interpreter assistance if required.

Practice point If you observe any of the above during the consent discussion, do not proceed to the examination. Address the cue directly: slow down, invite questions, offer more time, or offer to reschedule. A **Patient Volunteer** who signs under visible uncertainty has not given the quality of consent the forms require.

4.6 How to Respond When a Cue Is Observed

When a verbal or non-verbal cue is observed, the **Qualified Professional** must respond immediately and proportionately. The following graduated response applies:

Cue observed	Required response
Mild hesitation or uncertainty during consent discussion	Pause. Invite questions. Offer more time or an opportunity to reschedule. As a minimum, do not proceed unless and until the Patient Volunteer provides clear consent to willingly proceed. Document the incident.

Non-verbal distress cue during examination	Pause the examination. Address the Patient Volunteer by name and check in directly: "I'm going to pause, are you comfortable to continue?" As a minimum, do not resume unless and until the Patient Volunteer provides clear consent to willingly proceed. Document the incident.
Verbal withdrawal or request to stop	Stop the examination immediately. Acknowledge the request clearly. Do not attempt to reassure the Patient Volunteer to continue. Ensure the Patient Volunteer is comfortable and offer support. Document the incident.
Freezing, dissociation or apparent trauma response	Stop the examination. Speak calmly and directly to the Patient Volunteer . Allow time and space. Do not proceed under any circumstances. Offer to arrange further support. Document the incident.
Any cue from a minor (verbal or non-verbal)	Stop the examination immediately. The minor consent form is explicit: the examination must not proceed if the minor objects, resists or appears distressed. No guardian instruction or event pressure overrides this. Document the incident.

4.7 Documentation of Cue-Related Decisions

Where a **Qualified Professional** observes a cue and takes action, whether pausing, checking in, or ceasing the examination and this must be reported and documented to the **Event Manager**.

The **Event Manager** is the key contact of the **Event Organiser**, the organisation that has facilitated the **Teaching Event**, such as a conference or workshop.

The **Event Manager** must record the report and the steps taken in line with organisational risk management processes and procedures.

Documentation and Risk Management Documentation should be recorded in line with the **Event Organiser's** policies and procedures and legislative reporting requirements for all minor **Patient Volunteers**.

5. Form-Specific Guidance

5.1 Invasive (Internal) Ultrasound — Consent to Invasive (Internal) Ultrasound Scanning for Teaching Purposes

This form applies to transvaginal and transrectal teaching examinations of adult **Patient Volunteers**. Key clinical context obligations include:

- Explain precisely which type of internal examination will occur (transvaginal and/or transrectal) — do not use only the generic term 'internal scan'.
- Describe the process of transducer cover application, gel lubrication, insertion technique and estimated duration inside the body.
- Clearly disclose the internal nature of the procedure in a private, comfortable environment before the day of the event wherever possible.
- Confirm the **Patient Volunteer** understands that one or more trainees may perform or assist with the examination under supervision.
- Confirm that the request to cease must be explicit and verbal. **Patient Volunteers** should know they do not need to physically resist; a clear verbal instruction is sufficient and will be respected immediately.

ASUM Standard Refer to the **ASUM Transvaginal Ultrasound Policy (2026)** and **Guideline on Performance of a Gynaecological Ultrasound Examination (2026)**. Chaperoning requirements under ASUM policy must be observed for all intimate examinations.

5.2 General and Pregnancy Ultrasound — Consent to General and Pregnancy Ultrasound Scanning for Teaching Purposes

This form may cover both external examination **Patient Volunteers** (including those who are pregnant). Specific considerations:

- The form uses conditional tick-boxes for external and internal components. Ensure clinical context is provided for each element being consented to — explain both if both are planned.
- Explain the ALARA (As Low As Reasonably Achievable) principle in plain language: that the **Qualified Professional** will use the minimum acoustic output necessary and will stop the examination if there is any concern for maternal or foetal welfare.
- Clearly state that the teaching scan is entirely separate from any clinically indicated ultrasound and that the **Patient Volunteer** should not attend the teaching session in lieu of a clinical scan.
- Advise that if an incidental abnormality is identified, the **Patient Volunteer** will be informed and directed to seek appropriate clinical follow-up. Do not offer provisional diagnostic opinions during the teaching session.
- Be sensitive to the **Patient Volunteer's** pregnancy-related concerns and anxieties, particularly regarding fetal well-being. Reassure regarding the established safety profile of diagnostic ultrasound but do not overstate certainty.

ASUM Standard Refer to **ASUM Guidelines for the Performance of First Trimester Ultrasound (2021)**, [ISUOG: Guidelines for the Performance of Third Trimester Ultrasound \(2024\)](#).

Note bioeffect considerations (thermal and mechanical indices) relevant to first-trimester examinations.

5.3 External Ultrasound of Minors Consent to Ultrasound Scanning of Minors for Teaching Purposes (external ultrasound examinations only)

This form applies to the external examination of **Patient Volunteers** under 18 years of age in Australia or under the age of 16 years of age for the purposes of independently consenting to the examination under section 36 of the Care of Children Act 2004 in New Zealand (noting that a child under 16 who demonstrates sufficient understanding may also be able to give effective consent). It requires the most careful attention to child safe practice.

Child Safety and Reporting	Engagement of minor Patient Volunteers for teaching purposes must be administered under the following: • Australia: National Principles for Child Safe Organisations. • New Zealand: Oranga Tamariki Ministry for Children Child Protection Policies for Organisations
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Key obligations:

Guardian Consent

- Identify and verify the legal authority of the consenting adult (parent or guardian). Where there is any doubt about authority to consent, do not proceed without legal or institutional confirmation.
- Provide full clinical context to both the guardian and the minor child, adapted to the child's age and maturity.
- Record the basis on which the consenting adult is authorised (e.g., parent, legal guardian) on the form.

The Minor's Assent

- The minor must be present during the consent discussion and must demonstrate an age-appropriate understanding of what will occur (Gillick competence assessment).
- Do not proceed if the minor objects, resists, or appears distressed at any point. This obligation persists throughout the examination and cannot be overridden by guardian consent.
- Use child-appropriate language. Visual aids or age-appropriate demonstrations (e.g., showing the probe, applying gel to the back of the hand) may assist.
- Ensure the minor understands that they can ask the procedure to stop at any time and that the **Qualified Professional** will stop immediately.

Support Person

- A parent or guardian must be present for the duration of any ultrasound examination of a minor. This is mandatory, not optional.

Privacy and Dignity

- Minimise unnecessary exposure of the minor's body. Expose only the body area required for the examination and recover as soon as the scan of that area is complete.
- Ensure adequate privacy screening is in place before the minor is positioned for the examination.
- Be alert to, and immediately respond to, any sign of distress, including non-verbal cues.

Photography, Recording and Image Projection

- Notify attendees that they are **not allowed** to photograph or record images of the minor **Patient Volunteer**.
- Obtain explicit consent for any recording or projection of images. Where minors are involved, the default position should be that images are not recorded or projected unless clearly necessary for teaching, and that identity protection measures are robust.
- Ensure the minor's face or identifying features are not included in any projected, photographed or recorded images.

6. Special Circumstances

6.1 Patient Volunteers Who May Lack Capacity

Where a **Qualified Professional** has any concern about a **Patient Volunteer's** capacity to provide informed consent (e.g., due to language barriers, cognitive impairment, acute distress, intoxication, or intellectual disability):

- Do not proceed with the teaching examination.
- Seek guidance from the event organiser and, if appropriate, the **Patient Volunteer's** treating clinician or legal guardian.
- Refer to applicable state/territory legislation regarding substitute consent for medical procedures.

6.2 Cultural and Religious Considerations

- Be sensitive to cultural or religious considerations that may affect willingness to participate, particularly in relation to intimate examinations or the presence of observers of a different gender.
- Offer, wherever operationally feasible, that the performing **Qualified Professional**, support person and/or chaperone be of the **Patient Volunteer's** preferred gender.
- Document any reasonable adjustments made to accommodate cultural or religious preferences.

6.3 Aboriginal, Torres Strait Islander, Māori Patient Volunteers

- Apply culturally safe practices consistent with the National Principles for Child Safe Organisations (Australia) or Oranga Tamariki Act 1989 (New Zealand) and be aware of cultural considerations relating to body examination, the presence of observers, and image recording that may be specific to the **Patient Volunteer's** community.

7. Documentation

Qualified Professionals must:

- Provide relevant information and clinical context to the **Patient Volunteer** and answer any questions that are asked to the satisfaction of the **Patient Volunteer**, before obtaining informed consent.
- Complete all sections of the **Qualified Professional** confirmation checklist on the relevant consent form as part of obtaining informed consent and before the examination commences.
- Ensure the **Patient Volunteer** (and guardian, where applicable) has signed and dated the form prior to commencement.
- Where the **Qualified Professional** who provides the information and clinical context to the **Patient Volunteer** is different from the **Qualified Professional** who performs the examination, each must be documented on the form.
- Report to the **Event Manager** any material departures from standard procedure (e.g. early termination of the examination, refusal after initial consent, or specific **Patient Volunteer** requests) to be recorded as per the **Event Organiser's** policies and procedures.

Note These guidelines are for **Qualified Professional** guidance only and do not constitute legal or clinical advice.

Qualified Professionals should seek independent legal advice when there is uncertainty regarding consent obligations in their jurisdiction.

ASUM contact: asum@asum.com.au | www.asum.com.au

8. Key Definitions

Reference	Details
Event Manager	• The designated representative of the Event Organiser who has primary responsibility for the planning, coordination, and operational management of the ultrasound education or training activity. The Event Manager serves as the principal contact for Patient Volunteers, Qualified Professionals, and other stakeholders, and is responsible for ensuring the event is conducted in accordance with applicable policies, procedures, and regulatory requirements.
Event Organiser	• The organisation responsible for planning, coordinating, managing, and delivering the Teaching

Minor	Event , including appropriate administration, supervision, and compliance with applicable policies and procedures.
	An individual who is under the age of 18 years in Australia. In New Zealand, an individual under the age of 16 years, being the age at which a young person may independently consent to medical, surgical or dental treatment or procedures under section 36 of the Care of Children Act 2004 (noting a child under 16 with sufficient understanding may also be able to give effective consent). (This is distinct from the general age of majority of 20 years under the Age of Majority Act 1970, which does not govern medical consent.)
Patient Volunteer	An individual who voluntarily undergoes an ultrasound examination, performed under the supervision of or by a Qualified Professional, for the purpose of education, training, or demonstration.
Qualified Professional	Means a qualified sonographer or healthcare professional working within their scope of practice or a medical practitioner who is specifically trained to perform the ultrasound examination.
Teaching Event	A structured educational activity, such as a conference, workshop, course, seminar, or other organised training session, in which ultrasound scanning is taught, demonstrated, or practised. A Teaching Event is facilitated by Qualified Professionals and is conducted for the purpose of developing knowledge, skills, and competency in ultrasound practice

8. Key References

Reference	Details
ASUM Consent Forms (2026)	- Consent to Intrusive (Internal) Ultrasound Scanning for Teaching Purposes - Consent to General and Pregnancy Ultrasound Scanning for Teaching Purposes - Consent to External Ultrasound Scanning of Minors for Teaching Purposes
ASUM Code of Conduct (2018)	Available at www.asum.com.au .

Children's Act 2014 (NZ)	Children's workforce safety-checking regime. Requires child protection policies for organisations working with children. www.legislation.govt.nz
Care of Children Act 2004 (NZ)	Governs parental responsibility and guardianship; relevant to authorisation to consent for minors. www.legislation.govt.nz
NSQHS Standard 2 — Partnering with Consumers Action 2.04 Informed Consent (AU)	ACSQHC Informed Consent Fact Sheet. https://www.safetyandquality.gov.au (URL printed on each ASUM consent form).
Gillick v West Norfolk and Wisbech AHA [1985] 3 All ER 402	Foundational authority on the Gillick competence, adopted and modified in Australian law through <i>Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case) (1992) 175 CLR 218</i> , alongside applicable state and territory consent legislation; and recognised and applied in New Zealand alongside the consent requirements of the <i>Code of Health and Disability Services Consumers' Rights</i> , particularly Rights 7 and 9, and section 36 of the <i>Care of Children Act 2004</i> .
HDC Code of Health and Disability Services Consumers' Rights 1996 (NZ)	Rights 6 and 7 govern informed consent. In addition, Right 8 (Right to Support), Right 9 (Rights in Respect of Teaching or Research) and Right 10 (Right to Complain) are directly applicable to the consent process for teaching ultrasound examinations. Health and Disability Commissioner. www.hdc.org.nz
Health and Disability Commissioner Act 1994 (NZ)	www.hdc.org.nz
Health Practitioners Competence Assurance Act 2003 (NZ)	www.legislation.govt.nz
Health Practitioners Competence Assurance Act 2003 (NZ)	Governs the registration and scope of practice of sonographers (as medical radiation technologists), in NZ administered by the Medical Radiation Technologists Board. www.mrtboard.org.nz
Health Practitioner Regulation National Law (AU)	As in force in each state and territory. AHPRA. www.ahpra.gov.au
Medical Radiation Technologists Board (MRTB)	Registration and scope of practice for sonographers (as medical radiation technologists) in New Zealand, under the Health Practitioners Competence Assurance Act 2003. www.mrtboard.org.nz
National Principles for Child Safe Organisations (AU)	Australian Human Rights Commission, 2019. www.humanrights.gov.au/our-work/employers/national-principles-child-safe-organisations

Oranga Tamariki Act 1989 (NZ)	Principal child protection statute. Establishes paramountcy of child welfare; mandatory reporting obligations. www.legislation.govt.nz
Pae Ora (Healthy Futures) Act 2022 (NZ)	Health equity obligations including for Māori. www.legislation.govt.nz
Privacy Act 2020 and Health Information Privacy Code 2020 (NZ)	Governs health information in NZ. Office of the Privacy Commissioner. www.privacy.org.nz
Privacy Act 1988 (Cth) (AU)	Australian Privacy Principles. www.oaic.gov.au
Working with Children legislation (AU)	Applicable state/territory legislation, refer to the relevant government authority for the jurisdiction of the teaching event.