Place Patient Form Label Here

CONSENT TO TREATMENT (PHC)

* 2 7 4 5 *

Consent Procedure

I hereby authorize _____ M.D./D.D.S./ _____ and such physicians, surgeons, anesthetists and hospital staff whose assistance is required, to perform the following test(s), treatment(s), procedure(s) and/or operation(s):

_____

_____

The nature and possible effects, including the significant risks and alternatives to this test, treatment or operation, have been explained to me and I understand the explanation and the alternatives.

If unexpected conditions are discovered during the above test, treatment or operation, I consent to such additional or alternative tests, treatments or operations as the health care provider named above finds immediately necessary.

I also agree to receive anaesthesia and such anaesthetics as may be considered necessary. I understand that it is my responsibility to refrain from driving a motor vehicle for 24 hours following my anaesthetic and to have a responsible adult accompany me home.

I understand that Providence Health Care participates in medical education and quality improvement and as a result I agree that:

1. supervised health practitioners-in-training who are in approved education programs may participate in my care;
2. tissues, bodily fluids, devices or implants removed in this procedure become the property of the hospital and may be used for such purposes, including teaching or research, as is approved by the hospital; and
3. my doctor or dentist may give information to the hospital about follow-up care in my doctor or dentist's office.

I understand that if I receive an implant/tissue from a source outside of Canada, Providence Health Care is required to provide information about me - including my name, address and the fact that I have this implant - to the provider of that implant/tissue so that I may be notified of any issues which arise about the device that could affect my health and safety. I further understand that it is possible that my personal information stored by the provider of the implant/tissue may be accessed by the government of that country without my knowledge or consent pursuant to applicable legislation. I authorize Providence Health Care to disclose my personal information to the provider of the implanted device or tissue as reasonably required.

X

Signature of patient	Date & time of signature
Signature of Substitute Decision Maker (Form ID - 2760 must be completed)	PRINT NAME
Signature of M.D./D.D.S/_____ obtaining consent	PRINT NAME
Witness signature (when MD not present at time of signing)	PRINT NAME

Place Patient Form Label Here

CONSENT TO TREATMENT (PHC)

* 2 7 4 5 *

Consent Procedure

DECLARATION BY INTERPRETER:

I have accurately interpreted the conversation between _____ (health care provider) and _____ (patient or substitute decision maker) and interpreted this document to _____ (patient or substitute decision maker), who told me that he/she understood the explanation and consents to the treatment described on the other side of this form.

X _____ _____

Signature of interpreter | Date & time of signature

_____

PRINT NAME

TELEPHONE CONSENT:

I have discussed the procedure outlined on the other side of this form and the expected benefits, significant risks, side effects, alternative course of action and the likely consequences of not having the treatment(s) with _____ (substitute decision maker) who is the patient's _____ (state relationship) and he/she has given verbal consent.

X _____ _____

Signature of M.D./D.D.S./_____ | Date & time of signature

_____

PRINT NAME

X _____ _____

Signature of witness | PRINT NAME

CERTIFICATE OF NEED FOR URGENT/EMERGENT HEALTH CARE:

I hereby certify that it is necessary to provide the following health care:_____ without delay in order to save this patient's life, to prevent serious physical or mental harm or to alleviate severe pain, and the patient is, in my opinion, incapable of giving or refusing consent, and has not previously indicated that consent would be refused. I have been unable to consult with any available substitute decision maker within a reasonable time in the circumstances.

X _____ _____

Signature of M.D./D.D.S./ _____ | Date & time of signature

_____

PRINT NAME

It is recommended, but not mandatory, that a second medical staff member (not a resident) of Providence Health Care signs this form.

I agree with the need for the health care set out above for this patient and with the opinion on incapability.

X _____ _____

Signature of M.D./D.D.S./_____ | Date & time of signature

_____

PRINT NAME