Lakeridge Health

CONSENT TO TREATMENT

I _____ hereby authorize _____,
(Print name of Patient or Substitute Decision Maker (SDM)) *(Name of Health Practitioner)*
and such physicians, and other health care practitioners whose assistance is required, to perform the following operation(s), anesthetic(s), test(s) and/or treatment(s):

_____

_____
(Proposed Treatment, Operative and/or Diagnostic Procedure(s))

I acknowledge that my health practitioner(s) and I have discussed the nature of the operation(s), test(s) and treatment(s), the alternatives, the associated benefits and potential risks, in a manner I understand. If any unexpected conditions are discovered during the above operation(s), test(s) and/or treatment(s), I consent to such operation(s), test(s) and treatment(s) which may be essential for the maintenance of life and vital function in addition to or in place of those authorized above.

I understand that my health practitioner may request a colleague who is a member of Lakeridge Health's privileged staff to replace him/her in the performance of operation(s), test(s) and treatment(s), so they may be carried out in a timely manner and I agree to this substitution.

I understand that Lakeridge Health, through its affiliations with accredited universities and colleges, provides clinical experience for student health practitioners. I therefore give consent for supervised health practitioners−in−training, who are in approved educational programs, to participate in my care. I also consent to the taking of intra−operative images including photographs, videos and radiographic images for educational purposes.

Blood Transfusions/Manufactured Blood Products

❑ Not applicable
❑ I consent to receive donor blood and/or blood products manufactured from donor blood
❑ I will not consent to receive the following _____

I acknowledge that the Most Responsible Practitioner and I have discussed the nature of transfusion of blood and blood products, the associated benefits, potential risks, side effects and alternatives in a manner I understand. I have been provided with or had read to me the Blood Transusion Fact Sheet (FORM #CAD0219).

_____	_____	_____
(Signature of Patient/SDM)	*(Print name)*	*(Date)*
_____	_____	
(Relationship to Patient)	*(Telephone Number)*	

Statement of Physician/Health Care Practitioner

I confirm that I have explained the nature of the treatment(s), the expected benefits, material risks, material side effects, alternate course of action and the likely consequences of not having the treatment(s) to the above patient/substitute decision maker and answered all questions.

_____	_____	_____
(Signature of Health Practitioner)	*(Print Name of Health Practitioner)*	*(Date)*

CONSENT TO TREATMENT

Where an Interpreter is Involved

I have accurately interpreted the conversation between _____ and
(Physician/Health Practitioner)
_____ *(Patient/SDM)*

_____	_____	_____
(Signature of Interpreter)	*(Print Name)*	*(Date)*

Mode of Communication _____

Witness to Telephone Consent

I confirm that I have explained by telephone, the nature of the treatment(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatment(s) to _____ and answered all questions. _____
(Patient/SDM) *(Patient/SDM Phone Number)*

_____	_____	_____
(Signature of Physician/Health Practitioner)	*(Print Name)*	*(Date)*

_____	_____	_____
(Signature of Telephone Witness)	*(Print Name of Telephone Witness)*	*(Date)*

Consent to Treatment of Non−Ontario and Other Foreign Residents

I, _____ , agree the relationship between myself and Lakeridge Health, its staff, Dr._____,and his/her designate(s), shall be governed by and construed in accordance with the laws of the Province of Ontario. I, _____ acknowledge the treatment, operative and/or diagnostic procedure(s) described will be performed in the Province of Ontario. The Courts of the Province of Ontario shall have exclusive jurisdiction to entertain any complaint, demand, claim, or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. Should I enter into any legal proceedings, I hereby agree I will commence any such legal proceeding in the Province of Ontario and only in the Province of Ontario, and I hereby submit to the jurisdiction of the Courts of the Province of Ontario.

_____	_____	_____
(Signature of Patient/SDM)	*(Print Name of Patient/SDM)*	*(Date)*

_____	_____	_____
(Signature of Health Practitioner)	*(Print Name of Health Practitioner)*	*(Date)*

Health Practitioner's Statement for Emergency Use Only

I am proceeding with Emergency Treatment(s) identified on this consent because the patient meets the Conditions for Emergency Treatments without Consent outlined in the Health Care Consent Act and the Lakeridge Health Consent toTreatment Policy.

_____	_____	_____
(Signature of Health Practitioner)	*(Print Name of Health Practitioner)*	*(Date)*