CONSENT TO TREATMENT

I, ____________________________________________________________, hereby consent to the following treatment, investigational procedure or operation: ____________________________________________________________ (Print and include the date, site and level if applicable. Do not abbreviate.)

To be performed upon ________________________________________________ by ____________________________________________________________, or their delegate and by other physicians and health practitioners whose assistance is required. If there are any unexpected conditions or problems during treatment, I consent to such additional treatments which in the opinion of the Health Practitioner performing the procedure(s) may be necessary to maintain my life.

I consent to the administration of anesthetic medication by or under the supervision of a member of the medical staff who has privileges at St. Joseph's Healthcare Hamilton.

I acknowledge that the Health Practitioner has explained the nature of the above treatment or procedure, its expected benefits, material risks and side-effects, alternative courses of action and the likely consequences of not having this treatment.

I understand that St. Joseph's Healthcare Hamilton (SJHH) is a teaching hospital and agrees to have supervised health practitioners-in-training participate in my treatment and care.

I give consent to the videotaping, photography and use of other images for teaching and research purposes. I understand that if any such images can identify me, my expressed consent will be obtained prior to using such images for similar teaching or research purposes. Yes [ ] / No [ ]

I have had the opportunity to ask questions about the proposed treatment and have had my questions answered to my satisfaction. I understand and agree to the form and understand it.

Signature of Patient: ________________________________________________
Print Name of Patient: ________________________________________________

Signature of Substitute Decision Maker: ________________________________
Print Name of Substitute Decision Maker: ________________________________

Relationship to Patient: ________________________________________________

STATEMENT BY HEALTH PRACTITIONER

I declare that I have explained the nature of the treatment, procedure or operation, its expected benefits, material risks and side-effects, alternative courses of action and the likely consequences of not having this treatment. I understand this information provided to me and the answers I received to my questions.

Signature of Health Practitioner: ______________________________________
Print Name of Health Practitioner: ________________________________
Date: ____________________________________________________________

ADMINISTRATION OF BLOOD/BLOOD PRODUCTS

I acknowledge that the Health Practitioner has explained the nature of a blood transfusion(s) and/or administration of blood products, the expected benefits, material risks and side-effects, alternative courses of action and the likely consequences of not having this treatment. I understand this information provided to me and the answers I received to my questions.

CONSENT FOR BLOOD or BLOOD PRODUCTS

I agree to the administration of blood or blood products during the course of my treatment.

Date: ____________________________ Signature of Patient/Substitute Decision Maker: ________________________________

REFUSAL OF BLOOD or BLOOD PRODUCTS

Hereby refuse consent to the administration of blood or blood products and release and hold harmless the Health Practitioner(s), Hospital and its employees from any liability resulting from the failure to administer or continue to administer blood or blood products(s).

Date: ____________________________ Signature of Patient/Substitute Decision Maker: ________________________________