CONSENT TO TREATMENT

I, [Name], hereby consent to have the treatment/operation/procedure:

Right Clavicle open reduction, internal fixation & décompression

performed by (Health Practitioner) [Drs. [Names]], and will allow:

- Anesthetics, other medications and/or blood products, if needed;
- Any other treatment, operations and procedures needed in an emergency;
- The Health Practitioner to use the help of other Health Practitioners, including residents and students;
- The disposal of any tissue or parts that have been removed during the treatment/operation/procedure;
- Devices/medical products implanted during procedures may be registered with the corresponding vendor for quality control.

I confirm that (Health Practitioner) [Name] has explained the treatment/operation/procedure to me, and the risks, side effects and expected benefits of the treatment/operation/procedure;
- Has answered my questions about the treatment/operation/procedure;
- Has told me about other possible treatments;
- Has told me about the possible effects if the treatment/operation/procedure is not done.

I understand these explanations and I am satisfied with them.

<table>
<thead>
<tr>
<th>Initial</th>
<th>CONSENT TO COLLECTION OF SURPLUS TISSUE FOR RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I voluntarily agree to have surplus tissue made available to researchers after my surgery for use in research ethics board approved research projects.</td>
</tr>
<tr>
<td></td>
<td>I refuse to have surplus tissue made available to researchers after my surgery.</td>
</tr>
<tr>
<td></td>
<td>Not applicable (any surgeries where no tissues will be removed).</td>
</tr>
</tbody>
</table>

I have received, read and understood the patient information page describing global tissue collection project.

Patient name/Substitute decision maker (SDM) | Signature | Date (yyyy/mm/dd) |
--- | --- | --- |
[Name] (SDM) | [Signature] | [Date]