niagarahealth

Extraordinary Caring. Every Person. Every Time.

Consent to Assessment, Treatment, Operation, Procedure

(1) I, _____ hereby consent to the following assessment, treatment,
(print name of person signing consent form)

operation or procedure (referred to on this form as the "Procedure") _____
(print full name of the Procedure)

_____

to be performed on _____
(PRINT NAME OF PATIENT CLEARLY)

and performed by Dr. _____
(print name of physician / health practitioner performing the Procedure) (hereinafter called "the doctor").

(2) The doctor has informed me about the nature and gravity of the Procedure, its anticipated effects, any recognized significant risks and side effects of the Procedure, any available alternatives and the recognized significant risks associated with those alternatives. I understand and am satisfied with the information provided to me.

(3) The doctor has responded to my questions about the nature and gravity of the Procedure, its anticipated effects, any recognized significant risks and side effects of the Procedure, any available alternatives and the recognized significant risks associated with those alternatives. I understand and am satisfied with the explanations that have been provided to me.

(4) If the Procedure is an operation, I also consent to such additional or alternative treatments or operative procedures as in the opinion of the doctor are immediately necessary at the time of the operation.

(5) If the Procedure involves anaesthetic agents, I also consent to the administration of anaesthetic agents as may be deemed advisable.

(6) I further agree that in his/her discretion, the doctor may make use of the assistance of other surgeons and/or physicians and may permit them to order or perform all or part of the Procedure, and they shall have the same discretion in my assessment and/or treatment as the doctor.

(7) I further agree that medical students in training under qualified supervision, may observe and/or perform all or part of the Procedure the doctor or other surgeons and/or physicians permit them to observe and/or perform.

Patient Signature: _____ Date: dd/mm/yyyy _____

Physician / Health Practitioner Signature: _____ Date: dd/mm/yyyy _____

TEACHING, RESEARCH SUPPORT

I consent to the Niagara Health System taking photographs in the course of this Procedure for medical, scientific or educational purposes. I understand that I will not be identified in connection with the use of any photograph(s) taken in the course of this Procedure.

Patient Signature: _____ Date: dd/mm/yyyy _____

Physician / Health Practitioner Signature: _____ Date: dd/mm/yyyy _____

PATIENT NOT OF DECISION−MAKING CAPACITY

Consent given by: _____ _____
(Substitute Decision−maker) (Relationship to Patient)

Physician Signature: _____ Date: dd/mm/yyyy _____
(Physician / Health Practitioner Signature)

By Telephone to Dr. _____ _____
(Physician / Health Practitioner Signature)

INTERPRETER

Interpretation of consent form required due to: _____

Interpreted by: _____ to: _____

Witnessed by: (Physician / Health Practitioner Signature) _____ Date: dd/mm/yyyy _____