WILLIAM OSLER HEALTH SYSTEM
CONSENT TO DIAGNOSTIC OR OPERATIVE PROCEDURES OR ADMINISTRATION OF BLOOD OR BLOOD PRODUCT(S)

BRAMPTON CIVIC HOSPITAL
ETOBICOKE GENERAL HOSPITAL
PEEL MEMORIAL HOSPITAL

**Imprint Patient Hospital Card:**

Patient's Name _____

I hereby authorize _____ of the William Osler Health System,
Name of Health Practitioner
and whomsoever he/she may direct or delegate to assist him/her to perform the following:

Procedure _____
Full Name of operation(s), test(s) or treatment (s)

and such additional or alternative procedure(s) as are considered immediately necessary during the course of the said procedure(s). I further agree that in his/her discretion, the above-named practitioner may have the assistance of other physicians, surgeons, anaesthetists and health practitioners and may permit them to perform all or part of the procedure(s).

I acknowledge that the above named Health Practitioner has explained to me the nature of the procedure(s), the expected benefits, material risks and material side effects. He/she also explained to me the alternative courses of action and the likely consequences of not having the procedure(s). I fully understand all the information provided to me.

I certify that I have read this form and fully understand it.

_____ _____
Signature of Patient /Substitute Decision-maker Date

_____
Print Name of Substitute Decision Maker

☐ I have had a discussion about transfusion of blood and blood products with the above named health practitioner

## BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS

☐ I consent to receive donor blood. I have received and had the opportunity to read the brochure *Transfusion of Blood and Blood Products.*

☐ I consent to receive blood products manufactured from donor blood.

I acknowledge that the nature of the treatment (s), the expected benefits, material risks, material side effects, alternative courses of action and the likely consequences of not having the treatment(s) have been discussed with me and all questions have been answered to my satisfaction.

_____ _____
Signature of Patient / Substitute Decision Maker Date

## Statement of Health Practitioner

I confirm that I have explained 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 the above patient/substitute decision maker and answered all questions.

_____ _____
Signature of Health Practitioner Date

## Interpreter Declaration

I believe that I have accurately interpreted the conversation between the above named Health Practitioner and above named patient / Substitute Decision Maker and I believe the person understood the information given.

Signature of Interpreter _____ Print Name _____

Mode of Communication _____ Date _____

## Telephone Consent

I confirm that I (the above named Health Practitioner) have explained by telephone, the nature of the treatment, the expected benefits, material risks, material side effects, alternative course of action and likely consequences of not having the treatment and answered all questions to the Substitute Decision Maker:

Name of Substitute Decision Maker _____

Signature of Health Practitioner _____ Date _____

Signature of Third-party _____ Date _____

## Health Practitioner's Statement for Emergency Use Only

If in the opinion of the Health Practitioner a delay for the purpose of obtaining consent would put the person at risk of serious bodily harm or prolonged severe suffering, the Health Practitioner should complete the following statement:

I, _____, believe that the delay in obtaining consent to perform

_____ would put
Identify the diagnostic or operative procedure(s), treatment or administration of blood or blood products

_____ at risk of serious bodily harm or prolonged severe suffering.
Patient Name

Signature of Health Practitioner _____ Date _____