SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: mm / dd / yy

Consent to Treatment *- Please review and complete all applicable boxes.*

Verification of Consent Discussion

I, _____, authorize _____ and/or
(print first, last name of patient) *(proposer of treatment)*

other healthcare practitioners, physicians or hospital staff that he/she might designate to assist him/her, or to perform the following operation(s), test(s), treatment(s):

_____

_____ on myself.

The proposer of treatment has explained to me the diagnosis, recommended treatment, expected benefits, related significant risks, alternative treatments (including the option to not treat), as well as significant risks associated with those options, in a manner that I have understood.

If the proposer of treatment discovers a different, unsuspected condition at the time of treatment, I authorize him/her to perform such operation(s), test(s) and treatment(s), which are thought to be essential for the maintenance of life or vital function, in addition to or in place of those authorized above.

The proposer of treatment has explained to me that anesthetics may be necessary and are to be administered by a person responsible for this service.

PATIENT'S STATEMENT

I acknowledge that:

- I have had a consent to treatment discussion with the proposer of treatment.
- I have had the opportunity to ask questions. The proposer of treatment has answered all my questions to my satisfaction.
- I understand I can withdraw this consent any time before the beginning of the operation(s), test(s) and treatment(s).

❑ Patient ***OR*** ❑ Substitute Decision Maker (SDM) in the case of an incapable patient

Name: *(print first, last)* _____ _____
(Relationship if signed by other than patient)

Signature: _____ **Date:** ____/____/____ **Time:** _____

PROPOSER OF TREATMENT STATEMENT: (This box may be used by proposer of treatment for documentation purposes if the consent discussion has not been documented elsewhere.)

I have explained to _____ the diagnosis, recommended treatment, expected
(patient or substitute decision maker)
benefits, related significant risks, alternative treatments (including the option to not treat) and significant risks to the patient related to the operation(s), test(s), and treatment(s), written above.I have answered all questions raised by the patient to the best of my knowledge. I believe the patient has been adequately informed.

Name of Proposer of Treatment: *(print first, last)* _____ **Discipline:** _____

Signature: _____ **Date:** ____/____/____ **Time:** _____

SL1271A_11 (03/16) "Southlake Regional Health Centre" Review (03/19)

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Consent to Treatment *- Please review and complete all applicable boxes.*

EMERGENCY TREATMENT WITHOUT CONSENT

I certify that, due to the urgent need for operation(s), test(s) and/or treatment(s), I am unable to obtain informed consent prior to the operation(s), test(s) and treatment(s). I have no knowledge of an advanced directive or other information indicating that receiving operation(s), test(s) and treatment(s) in these circumstances would be rejected by this patient. I have documented on the patient's health record the rationale for the operation(s), test(s), and treatment(s).

Name of Proposer of Treatment: *(print first, last)* _____ M.D.

Signature: _____ **Date:** ____/____/____ **Time:** _____

TELEPHONE CONSENT FROM SUBSTITUTE DECISION MAKER:

I confirm that I have explained to _____ _____
(Substitute Decision Maker) *(Relationship to patient)*

the diagnosis, recommended treatment, expected benefits, related significant risks, alternative treatments (including the option to not treat) and significant risks to the patient. I have answered any questions by the substitute decision-maker to the best of my knowledge. I believe the substitute decision-maker has been adequately informed.

Name of Proposer of Treatment: *(print first, last)* _____ **Discipline:** _____

Signature: _____ **Date:** ____/____/____

Telephone Number: _____ **Time of Call:** _____

Other Healthcare Professional Witnessing Consent Discussion: *(print first, last)*

_____ **Discipline:** _____

Signature: _____ **Date:** ____/____/____ **Time:** _____

IF ANY INTERPRETER IS USED TO COMPLETE ANY PART OF THIS FORM COMPLETE BELOW:

❑ Internal interpreter ❑ External Interpreter

Name of interpreter: *(print first, last)* _____

Name of Interpreter Service Utilized: _____

OUT OF COUNTRY RESIDENTS

Note: The Proposer of Treatment must ensure the "Governing Law and Jurisdiction of Medical Liability SL1316_01" has been signed and is on the Patient Health Record. This is available for printing via the Intranet at Governing Law & Jurisdiction form SL1316 02/12.

SL1271A_11 (03/16) "Southlake Regional Health Centre" Review (03/19)