PATIENT IDENTIFICATION

QUINTE HEALTH

CONSENT TO TREATMENT

I hereby authorize ____and such physicians, surgeons, anaesthetists and other health practitioners whose assistance is required, to perform the following operation(s), test(s) and treatment(s):

____

____

____

I acknowledge that ______________________________ and I have discussed the nature of the operation(s), test(s) and treatment(s), the associated benefits and potential risks, in a manner that I understood. If any unexpected conditions are discovered during the above operation(s), test(s) and treatment(s), I consent to such operation(s), test(s) and treatment(s) which may be essential for the maintenance of life or vital function in addition to or in place of those authorized above. I understand that any organ or tissue specimen removed during the procedure may be used for further necessary clinical investigation, for quality assurance or for teaching purposes.

☐ **I DECLINE the use of this surgical specimen for further clinical investigation, quality assurance or teaching.**

__________________________ __________________________ ____________________

Signature of Patient **PRINT NAME** **Date YYY/MM/DD**

____________________________________ __________________________

Signature of Substitute Decision Maker **PRINT NAME**

____________________ __________________________________

Date YYY/MM/DD **Relationship to Patient**

PATIENT IDENTIFICATION

QUINTE HEALTH

CONSENT TO TREATMENT

TELEPHONE CONSENT

I confirm that I have explained by telephone, 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:

____ and answered all questions.
Substitute Decision Maker.

______________________________	____________________________	_________________
Signature of Witness	**PRINT NAME**	**Date YYYY/MM/DD**

INTERPRETER DECLARATION

I believe I have accurately interpreted the conversation between ________________________
Physician/Health Care Practitioner

and _____________________________ and I believe the person understood the information given.
Patient / Substitute Decision Maker

____	______________________________
Signature of Interpreter	**PRINT NAME**
____	_________________________
Mode of Communication	**Date YYYY/MM/DD**

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) identified on this consent because the patient meets the Conditions for Emergency Treatment without Consent outlined in the Health Care Consent Act and the Quinte Health Consent to Treatment policy 2.10.3.

____	________________________________
Signature of Physician/Health Care Practitioner	**PRINT NAME**

____
Date YYYY/MM/DD