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