JOSEPH BRANT HOSPITAL

Patient information Label

Consent to Treatment, Investigative Procedure, Operation or Administration of Blood or Blood Product(s)

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 this Physician/Healthcare Practitioner and I have talked about this operation, test or treatment, and associated benefits and the potential risks. I understand all of these. If there are any unexpected conditions or problems found during my operation, test or treatment, I consent to having the Physician/Healthcare Practitioner perform any other procedures which may be essential for the maintenance of life or vital function in addition to or in place of those authorized above.

☐ I consent to the administration of anaesthesia by the Anaesthetist assigned to the above operation, and to the use of such anesthetics as he/she may deem advisable during the course of the operation.

☐ I understand that Joseph Brant Hospital provides clinical experience for student Healthcare Practitioners. I, therefore, give consent for supervised Healthcare Practitioners-in-training, who are in approved education programs to participate in my care.

Signature of Patient: _____ Print name of Patient: _____

Signature of Substitute Decision Maker: _____ Print name of Substitute Decision Maker: _____

Relationship to Patient: _____ Date (dd/mm/yyyy): ____ / ____ / _____

Transfusion of Blood/Blood Products(s)

I consent to receive blood products manufactured from donor blood. I have received and had the opportunity to read the brochure "Knowing More About Blood Transfusions."

I understand the benefits, risks and alternatives to this treatment. I do not have any questions or concerns.

Signature of Patient/Substitute Decision Maker: _____

Print Name of Patient/Substitute Decision Maker: _____

Date (dd/mm/yyyy): ____ / ____ / _____ Time: _____

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Telephone Consent from the Substitute Decision Maker (page 1 must also be completed)

Print name of Substitute Decision Maker: _____

Relationship to Patient: _____ Telephone: _____

I have read the Consent Form to the Substitute Decision Maker named above. The Substitute Decision Maker has agreed to this treatment being performed.

Signature of Healthcare Practitioner: _____ Print name of Healthcare Practitioner: _____

Signature of Healthcare Practitioner: _____ Print name of Healthcare Practitioner: _____

Date (dd/mm/yyyy): ____ / ____ / _____ Time: _____

Translation/Communication Declaration

I believe I have accurately translated/communicated the conversation between _____
Physician/Healthcare Practitioner

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

Signature of Translator: _____ Print name of Translator: _____

Mode of Communication: _____ Date (dd/mm/yyyy): ____ / ____ / _____ Time: _____

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 Healthcare Consent Act - 1996, s. 25.1.

Signature of Physician/Healthcare Practitioner: _____

Print Name of Physician/Healthcare Practitioner: _____

Date (dd/mm/yyyy): ____ / ____ / _____ Time: _____

Refusal of Blood/Blood Product(s)

Name of Healthcare Practitioner _____ has explained to me the nature of a blood transfusion(s) and/or the administration of blood product(s), the expected benefits of the transfusion(s) and/or the administration of blood product(s), and the alternative courses of action including the likely consequences of not having the transfusion(s) and/or the administration of blood product(s). I understand the explanation and am satisfied that my questions have been answered . I hereby REFUSE CONSENT to the transfusion(s) and/or administration of blood product(s).

Signature of Patient or Substitute Decision Maker: _____

Signature of Patient or Substitute Decision Maker: _____

Relationship to Patient: _____ Date (dd/mm/yyyy): ____ / ____ / _____ Time: _____