GUELPH
GENERAL HOSPITAL

CONSENT TO TREATMENT, INVESTIGATIVE PROCEDURE, AND/OR OPERATION

I, _____, consent to the following treatment, investigative procedure,
Name of Patient/Substitute Decision Maker (SDM)
and/or operation:

_____

_____

to be performed upon _____ by _____
Name of Patient Name & Designation of Health Professional
or their designate, and such physicians and other health professionals whose assistance is required.

I acknowledge that the health professional identified above has explained this treatment or procedure:

- its risks & benefits;
- material side effects;
- alternative course of treatment or procedure;
- and consequences of not having or delaying this treatment or procedure.

I have had an opportunity to ask questions and I fully understand all of the information explained.

I consent to such additional alternative treatment, investigative procedure, and/or operation, which in the opinion of the Health Professional performing the procedure(s) are reasonably necessary. I also consent to the administration of anaesthesia for any of these purposes as may be required.

I agree that other members of the medical, midwifery or health professional staff of the Guelph General Hospital other than the said Health Professional may perform or assist in treatment, investigative procedure, and/or operation and that other including students under their supervision and direction may assist them as required.

I consent to the administration of blood and/or blood products _____ Yes _____ No ❑ Check if not applicable
Initials of patient/SDM Initials of patient/SDM

Statement of Declaration

I declare that I fully understand the information provided about the above mentioned treatment, investigative procedure, and/or operation, and the administration of blood/blood products if indicated above.

_____ _____
Date dd/mm/yyyy Signature of Patient or Substitute Decision Maker

Statement of Health Professional

I declare that I have explained the nature of the treatment, the expected benefits and risks, side effects, the alternative courses of action and the likely consequences of not having the treatment and I have responded to any and all questions about such matters.

_____ _____
Date dd/mm/yyyy Signature of Health Professional

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Statement of Witness to Consent by Telephone

I have witnessed over the telephone the consent given to _____
Health Professional Name & Professional Designation

by _____ acting as substitute decision maker for
Name of SDM / Relationship to Patient/Telephone Number

_____ to the above mentioned treatment, investigative procedure,
Name of Patient

and/or operation, and transfusion of blood/blood products if applicable.

_____ _____
Signature & Printed Name of Witness Date dd/mm/yyyy

Statement of Interpreter

I declare that I have accurately translated this form for the patient/substitute decision maker referred to below and translated the discussion between _____ and _____
Name & Designation of Health Professional Name of Patient / SDM

to the above mentioned treatment, investigative procedure and/or operation and transfusion of blood/blood products if applicable.

_____ / _____ _____
Printed Name of Interpreter / Signature / Telephone Number Date dd/mm/yyyy

Instructions for Completion

1. The Health Professional proposing the treatment, investigative procedure, and/or operation is responsible for informing the patient (or substitute decision maker of incapable patient) of the expected risks, benefits, material side effects, alternative courses of treatment and the consequences of not having this treatment, investigative procedure, operation and/or administration of blood or blood product(s).
2. The preamble on the front of the written consent form including the treatment, investigative procedure, and/or operation is described in oridinary language, includes the site and side and is written in full. If consent is being obtained for blood/blood products only, blood/blood products is listed in the preamble.
3. The patient/substitute decision maker completes the statement of declaration on the written consent only after the Health Professional proposing the treatment gives all explanations and all questions are answered.
4. The patient/SDM initials either yes/no indicating consent for blood and/or blood products. Should this section not be applicable in this situation, the Health Professional obtaining consent checks the box indicating it is not applicable.
5. The Health Professional obtaining consent completes in full the Statement of Health Professional on the written consent certifying that he/she provided the required information and responded to questions.
6. When the patient is unable to sign the consent for reasons of incapacity, the Health Professional should obtain the consent of the substitute decision maker (SDM) after providing the explanations referred to #1 above and request that the SDM sign the written consent form.
7. If an interpreter is required, the interpreter should sign the interpreter's box on the written form and print their name and telephone number.
8. A witness to the consent obtained by telephone should sign the telephone consent box and print his/her name and include the telephone number of the SDM.

Health Professional Statement for Emergency Use

If in the opinion of the Health Professional a delay for the purpose of obtaining consent would put the patient at risk of serious bodily harm or prolonged suffering, the Health Professional should complete the following statement:
I, _____ believe that the delay in obtaining consent to perform
Printed Name & Designation of Health Professional

the treatment, investigative procedure, and/or operation described above would put
_____ at risk of bodily harm or prolonged severe suffering.
Name of Patient

_____ _____
Date dd/mm/yyyy Signature of Health Professional

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