CONSENT FOR TREATMENT, SURGICAL OPERATION, PROCEDURE OR DIAGNOSTIC TEST

SECTION A: Consent for Treatment, Surgical Operation, Procedure or Diagnostic Test (i.e. Proposed Treatment)

I, ______________________________ or ______________________________
Full Name of Patient — Substitute Decision Maker (SDM)

the ______________________________ of ______________________________
Relationship of Patient — Name of Patient

have had the nature of the proposed treatment explained to me along with the expected benefits of that treatment. I have been advised of the risks and side effects of the proposed treatment as well as other treatment available to me. I have been informed of the likely consequences of not proceeding with the proposed treatment. I have had the opportunity to ask questions about the proposed treatment and have had my questions answered to my satisfaction. I understand the information provided to me and give consent to the following treatment:

____
Treatment

to be performed by ______________________________ and his/her team.
Full Name of Healthcare Practitioner

I understand that any tissues/organs removed during care may be retained and used for the purposes of diagnostic examination, education or research and will be disposed of by the hospital based on standards governing the disposal of such material with the exception of: ______________________________

______________ ______________ ______________ ______________
Date YY/MM/DD — Time — Signature of Patient — or — Signature of SDM

SECTION B: TELEPHONE CONSENT

I am the healthcare practitioner proposing the operation, treatment or procedure. I have spoken by telephone with

______________________________, as that person is not available to attend at the hospital to sign the written
Name of SDM

consent form. I have obtained an informed consent over the telephone for the operation, treatment, procedure or diagnostic test known as:

____
Treatment

and have requested that the SDM attend at the hospital as soon as possible to sign the written consent form.
Date and Time of Telephone Call:

______________ ______________ ______________________________
Date YY/MM/DD — Time — Signature of Healthcare Practitioner

SECTION C: STATEMENT OF HEALTHCARE PRACTITIONER

I, ______________________________ am the healthcare practitioner proposing and/or
Full Name of Healthcare Practitioner Proposing Treatment

performing the treatment noted above. I have explained the nature of the treatment, the expected benefits, risks and side effects, alternative courses of treatment and the likely consequences of not proceeding with the proposed treatment to the patient/SDM. I have answered the questions of the patient/SDM to the best of my ability. To the best of my knowledge, the patient/SDM is giving his or her informed consent to the proposed treatment voluntarily.

______________ ______________ ______________________________
Date YY/MM/DD — Time — Signature of Healthcare Practitioner

NOTE: This Consent Form is NOT to be used for blood transfusions; please use "Consent for Administration of Blood Products" form.