



PATIENT IDENTIFICATION

QUINTE HEALTHCARE CORPORATION

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 YYYY/MM/DD

Signature of Substitute Decision Maker

PRINT NAME

Date YYYY/MM/DD

Relationship to Patient



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

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 QHC Consent to Treatment policy 2.10.3.

Signature of Physician/Health Care Practitioner PRINT NAME
Date YYYY/MM/DD