ST JOSEPH'S HEALTH CENTRE TORONTO

Name: _____
Male ☐ Female ☐
J #: _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

CONSENT TO TREATMENT

PATIENT NAME (PRINT): _____

TREATMENT (PRINT): _____

_____

No abbreviations

CONSENT TO BLOOD TRANSFUSION / MANUFACTURED BLOOD PRODUCTS

☐ I consent to receive donor blood
☐ I do NOT consent to receive donor blood
☐ I consent to receive blood products manufactured from donor blood
☐ I do NOT consent to receive blood products manufactured from donor blood

CONSENT STATEMENT:

I have discussed with _____ and understand:
Health Care Professional Name and Designation (Print)

- the reason for the above treatment and what will happen during the treatment as explained to me;
- the intended effect of the treatment and the significant risks that might occur with the treatment;
- any other possible options for care and likely risks of not having the treatment;
- that other physicians, hospital staff, may provide or assist in the treatment; and
- that this is a teaching hospital, students and trainees may provide or assist in the treatment.

By signing this form I agree:

- to additional treatments, tests, or operations that are considered necessary and ancillary to this treatment;
- to be given general, intravenous sedation, or other anesthetics for the above treatment as may be needed; and
- that I have had the chance to ask questions, and these questions have been answered to my satisfaction.

I consent to treatment.

ADDITIONAL COMMENTS:

Signature of Patient _____ **Date** _____

Signature of Substitute Decision Maker (if required) _____ **Substitute Decision Maker Name (Print)** _____

Relationship to Patient _____

INTERPRETER SERVICES / LANGUAGE LINE USED IN DISCUSSION ☐ **YES** ☐ **NO**

SEE REVERSE FOR CONSENT OBTAINED BY TELEPHONE, EMERGENCY TREATMENT, AND INSTRUCTIONS FOR COMPLETION.

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Name: _____
Male ☐ Female ☐
J #: _____
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_____
Telephone: _____
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CONSENT TO TREATMENT

STATEMENT OF CONSENT OBTAINED BY TELEPHONE

I have obtained by telephone the consent given

by _____ acting as Substitute Decision Maker (SDM)
Name of SDM, relationship to Patient, Telephone Number (Print)

for _____ to the above mentioned treatment.
Name of Patient (Print)

Date	**Health Care Professional (Signature)**	**Health Care Professional Name (Print)**
_____	_____	_____

EMERGENCY TREATMENT WITHOUT CONSENT

If, in the opinion of the health care professional, a delay for the purpose of obtaining consent would put the person at risk of serious bodily harm or prolonged suffering, the health care professional should complete the following statement:

I, _____ believe/believed that the delay in obtaining
Health Care Professional Name and Designation

consent to perform _____ would/ would have
Treatment (Print)

put _____ at risk of serious harm or prolonged severe suffering.
Patient Name (Print)

Date	**Health Care Professional (Signature)**	**Health Care Professional Name (Print)**
_____	_____	_____

INSTRUCTIONS FOR COMPLETION

1. The Health Care Professional proposing the treatment is responsible for informing the patient (or SDM when the patient is incapable) of the expected benefits, material risks and side effects, alternative courses of action and the consequences of having or not having this treatment, and obtaining the consent prior to the performance of such treatment.
2. The treatment is described in ordinary language and includes the site written in full where appropriate. Abbreviations are not to be used.
3. The patient (or SDM when the patient is incapable) signs the consent only after the Health Care Professional proposing the treatment provides the required information and answers any questions. If the patient/SDM does not consent to a portion of the form, that line will be struck out and initialed by the patient/SDM and the physician.
4. When the patient is unable to sign the consent for reasons of incapacity, the Health Care Professional will obtain the consent of the SDM following the same process.
5. Consent may be obtained by telephone and in such cases the Health Care Professional should sign the telephone consent section and print his/her name and include the telephone number of the SDM.
6. Refer to Consent to Treatment Policy #SJ 04-06-01.