Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION

Treatment/Operation/Test: *(Do not use abbreviations – write out in full)* _____

_____

I consent to the proposed operative procedure(s), treatment(s) or test(s) described above.

I confirm that the anticipated nature, benefits, risks and side effects of the above have been explained to me, including the anticipated nature, benefits, risks and side effects of any alternative course(s) of action and likely consequences of not having the treatment/operation/test. I understand that other qualified individuals may assist in the treatment/operation/test, this may include qualified medical learners. Any questions I have asked have been answered to my satisfaction.

_____ _____ _____

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

_____

If signed by SDM, state of relationship to patient

If patient is a U.S. or foreign resident, please complete Jurisdiction of Medical Liability Waiver on the reverse of this form

I have read/interpreted/communicated the above consent to treatment information for the patient/SDM.

_____ _____

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME

TELEPHONE CONSENT

I confirm that I have explained by telephone to _____ the nature of

Name of Substitute Decision Maker

the stated treatment(s), operative procedure(s), or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and the likely consequences of not having the treatment/operation/test and have answered all their questions.

_____ _____ _____

Signature of Physician/Proposer of Treatment | PRINT NAME/NAME STAMP | Date (dd/mm/yyyy)

_____ _____ _____

Signature of 3rd Party of Telephone Consent | PRINT NAME | Date (dd/mm/yyyy)

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) as stated on the reverse of this consent because the patient meets the Conditions for Emergency Treatment without Consent as outlined in **Mackenzie Health's Consent to Treatment Policy** and the **Health Care Consent Act.**

_____ _____ _____

Signature of Physician/Proposer of Treatment | PRINT NAME/NAME STAMP | Date (dd/mm/yyyy)

TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE TREATMENT

(N.B. Failure to complete this section of the consent form may result in the withholding of treatment to this patient.)

I confirm that I have explained the nature of the above operative procedure(s), treatment(s) or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and likely consequences of not having the treatment(s) to the above patient / substitute decision maker and answered all their questions.

_____ _____ _____

Signature of Physician/Proposer of Treatment | PRINT NAME/NAME STAMP | Date (dd/mm/yyyy)

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CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION (Continued)

JURISDICTION OF MEDICAL LIABILITY WAIVER FOR TREATMENT OF U.S. AND OTHER FOREIGN RESIDENTS

I agree that the relationship between myself and Mackenzie Health, its staff, delegates, physicians and other independent health care practitioners providing medical or other health care and treatment to me shall be governed by and construed in accordance with the laws of the Province of Ontario. I acknowledge that the Courts of the Province of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action. I hereby agree that I will commence any such legal proceedings in the Province of Ontario and I hereby submit to the exclusive jurisdiction of the Ontario Courts.

_____ _____ _____

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

I have read/interpreted/communicated the above information regarding the Jurisdiction of Medical Liability Waiver to the patient/SDM.

_____ _____

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME

BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS

☐ **NOT APPLICABLE**

I consent to receive donor blood and/or blood products manufactured from donor blood.
I acknowledge that the benefits and risks of receiving a donated unit of blood, including blood products manufactured from donor blood, have been discussed with me and all questions have been answered to my satisfaction. I have received the "Patient Information on Transfusion" brochure.

_____ _____ _____

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

_____

If signed by SDM, state relationship to patient

I have read/interpreted/communicated the above information regarding blood and blood products to the patient/SDM.

_____ _____

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME