WOODSTOCK HOSPITAL
Woodstock, ON

REQUEST AND CONSENT TO SURGICAL OPERATION, DIAGNOSTIC TEST OR MEDICAL TREATMENT

PIN NUMBER VISIT NUMBER

PATIENT LAST NAME PATIENT 1ST NAME PATIENT MIDDLE NAME

TELEPHONE

DOB MMM DD YYYY AGE SEX ONT HEALTH CARD NUMBER

FAMILY PHYSICIAN

Health Practitioner Proposing This Treatment:_____

Treatment:_____

_____

Surgery Date:_____ ☐ Sameday Admit ☐ Elective Admit ☐ One Day Stay
MMM DD YYYY ☐ Endoscopy Clinic ☐ Outpatient Clinic ☐ Inpatient

Part 1 – TO BE COMPLETED BY THE PATIENT OR SUBSTITUTE DECISION MAKER

I, _____ am ☐ the patient: or

☐ the substitute decision maker of the person named above _____
(printed name and relationship)

I request and consent to the following:

1. The treatment, operation or test(s) being proposed by the health practitioner as specified above
2. Any further or alternate procedure(s) found to be necessary on an emergency basis during the treatment
3. All procedure(s) and test(s) necessary to the treatment including pregnancy testing as applicable
4. Other health practitioners may assist in the treatment(s), as directed by the health practitioner
5. The administration of any drugs and anaesthetic as required for the treatment and further or alternate emergency procedures
6. The administration of blood or blood products if deemed medically necessary before, during and after the procedure
7. The disposal of any tissue or parts which may be removed during the treatment
8. Blood testing for risk assessment purposes in the event a health care provider is exposed to blood or body fluids during care (blood testing includes screening for the presence of Hepatitis B, Hepatitis C and HIV antibodies.) In the event the above named blood test results are positive, the results will be reported to me, the exposed health care provider and the Medical Office of Health

I acknowledge and agree that:

1. The health practitioner has explained to me the nature of the treatment(s) to be undertaken, the alternative course of treatment, and the consequences of not having the treatment
2. The health practitioner has advised me of the material risks and benefits of the treatment(s) and alternative course of treatment(s)
3. All of my questions or concerns about the proposed treatment(s), alternative course of treatment(s) expected benefits, material risks and side effects have been answered
4. No guarantee or assurance has been made to me about the results of the treatment(s)
5. This consent is being given on an informed and voluntary basis and may be revoked at any time prior to the treatment, operation or test

_____ _____
(Patient or Substitute Decision Maker's signature) (Date) MMM DD YYYY

PART 2 – TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE ABOVE TREATMENT

I, the health practitioner identified above, attest that I have obtained informed consent from the patient or substitute decision maker as required by the Woodstock Hospital and the Health Care Consent Act.

_____ _____
(Health Practitioner's signature) (Date) MMM DD YYYY

☐ Consent obtained by telephone

_____ _____ _____
Staff Member Signature Staff Member Name (printed) (Date) MMM DD YYYY