



WRHN

Waterloo Regional
Health Network

CONSENT TO TREATMENT, INVESTIGATIVE PROCEDURE, AND/OR OPERATION

I, _____, consent to the following treatment, investigative procedure,
Name of Patient/Substitute Decision Maker
and/or operation:

to be performed upon _____ by _____
Name of Patient Name & Designation of Health Professional
or their designate, and such physicians and other health professionals whose assistance is required.

I acknowledge that the health professional identified above has explained this treatment or procedure:

- its risks and benefits;
- material side effects;
- alternative course of treatment or procedure;
- and consequences of not having or delaying this treatment or procedure.

I have had an opportunity to ask questions and I fully understand all of the information explained.

I consent to such additional alternative treatment, investigative procedure, and/or operation, which in the opinion of the Health Professional performing the procedure(s) are reasonably necessary. I also consent to the administration of anaesthesia for any of these purposes as may be required.

I agree that other members of the medical, midwifery or health professional staff of the Grand River Hospital other than the said Health Professional may perform or assist in treatment, investigative procedure, and/or operation and that others including students under their supervision and direction may assist them as required.

I consent to the administration of blood and/or blood products _____ Yes _____ No
Initials Initials
of patient/SDM of patient/SDM

must check box if
blood products is not
applicable at this time

Name of information sheet provided to patient/SDM: _____

Statement of Declaration

I declare that I fully understand the information provided about the above mentioned treatment, investigative procedure, and/or operation, and the administration of blood/blood products if indicated above.

Date _____
(day / month / year)

Signature of Patient or Substitute Decision Maker

Statement of Health Professional

I declare that I have explained the nature of the treatment, the expected benefits and risks, side effects, the alternative courses of action and the likely consequences of not having the treatment and I have responded to any and all questions about such matters.

Date _____
(day / month / year)

Signature of practitioner proposing treatment

Statement of Witness to Consent by Telephone

I have witnessed over the telephone the consent given to _____
Health Professional Name & Professional Designation
by _____ acting as substitute decision maker for
Name of SDM / Relationship to Patient Telephone Number
_____ to the above mentioned treatment, investigative procedure,
Name of Patient
and/or operation, and transfusion of blood/blood products if applicable.
Date _____
(day / month / year) Signature and Printed Name of Witness

Interpreter

Interpretation service used _____
Contact information _____
Name of Interpreter Telephone Number

Health Professional Statement for Emergency Use

If in the opinion of the Health Professional a delay for the purpose of obtaining consent would put the patient at risk of serious bodily harm or prolonged suffering, the Health Professional should complete the following statement:

I, _____ believe that the delay in obtaining consent to perform
Printed Name & Designation of Health Professional
the treatment, investigative procedure, and/or operation described above would put
_____ at risk of bodily harm or prolonged severe suffering.
Name of Patient
Date _____
(day / month / year) Signature of Health Professional