Consent for Investigation, Treatment or Operative Procedure

I, _____ have had the nature and purpose of the proposed investigation, treatment or operative procedure explained to me. I understand the intervention, its risks, potential side effects and anticipated benefits. I have been informed about alternative courses of treatment available to me and the likely consequences of not proceeding with the proposed treatment. I am satisfied with the explanation I have had and my questions have been answered to my satisfaction. After consideration of the information provided to me, I have given consent to the following proposed intervention(s):

_____

_____

_____

to be performed by _____ and those whom he/she may designate as associates or assistants.

It has been explained to me that during the course of the proposed intervention unforeseen conditions may require additional or different interventions than described above. I also give consent to such additional or alternative investigations, treatments or operative procedures as the above named health professional deems immediately necessary.

I agree that the hospital may dispose of anything taken from my body during the intervention or retain for further routine investigations related to my care.

It has been explained to me that in the course of my treatment, I may require a transfusion of blood components and/or blood products. The nature, purpose and effects of the components and/or products have been described to me. I have been informed of and understand the benefits and risks associated with this therapy. Appropriate alternatives to the use of human blood along with the risks and benefits have also been discussed. I consent to the use of blood components and/or blood products if it becomes necessary at any time during the course of treatment including post-surgical blood transfusions if required.

☐ **I wish to refuse or limit my consent to blood transfusion. I have indicated this by completing the Refusal or Limited Consent for Transfusion of Blood Components and/or Blood Products**

_____ Date _____

Signature of patient

Or

_____ Date _____

Signature of Substitute Decision maker

Substitute Decision Maker (Print name): _____

Nature of Relationship to Patient: _____

Statement of Treating Physician or Authorized Health Professional

I confirm that I have explained the nature, associated benefits, potential side effects, alternative therapies and likely consequences of consenting to the proposed intervention and provided an opportunity to ask questions and answered all questions that were asked.

Signature of Physician or Authorized Health Professional

_____ CPSNS# _____

Print Name: _____ Date: _____