Soldiers' MEMORIAL HOSPITAL Orillia

Name (last, first)
Birthdate (yyyy-mm-dd)
OHIP number:

Consent to Treatment Plan or Procedure

Instructions: If person providing consent disagrees to an item on this form, strike out the text and have them initial it.	
Patient Name	
Details of Treatment Plan or Procedure. ***Write in full without abbreviations.***	
Initials ____	I confirm that the nature, benefits, risks, consequences, and alternatives of the treatment plan or procedure (as detailed above) and related matters have been explained to me. I am satisfied with and understand the information I have been given, and I consent to the treatment plan or procedure. _____ (*name / service*) will perform this treatment plan or procedure with the assistance of any other healthcare practitioners including medical students, residents and others in training.
____	I understand that I may, at any time, withdraw consent to this treatment plan or procedure (*as detailed above*) or any other related matter.
____	I understand that if an OSMH staff member is exposed to my blood or body fluids during my care, my blood will be tested for Hepatitis B, Hepatitis C, and HIV for the purpose of assessing the provider's risk. I acknowledge that the results of these tests will remain confidential and will only be used to support the treatment of the OSMH staff member. If any results are positive, they will be reported to public health authorities as required by law, and I will be offered appropriate treatment

Name of person(s) providing consent	Specify role of the person(s) providing consent ☐ Patient (adult) ☐ Parent (with legal authority to consent) ☐ Patient (mature minor) ☐ Guardian / Legal Representative ☐ POA for Personal care ☐ Other / Additional _____ ☐ Substitute Decision Maker (relationship to patient) _____
Phone #	

Signature of person providing consent	Date	Time

Witness Statement: I observed the person providing consent sign the consent form *(witness must be at least 18 years of age)*

Witness Name (*print)*	Signature	Date	Time

Most Responsible Health Practitioner Statement

I have explained the treatment plan or procedure to the person providing consent. In my opinion, this person understands the nature, benefits, risk, consequences, and alternatives.

Name	Signature	Date

Soldiers' MEMORIAL HOSPITAL Orillia

Name (last, first)
Birthdate(yyyy-mm-dd)
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Consent to Treatment Plan or Procedure

Telephone Fax Consent			
Consent given via ☐ Telephone ☐ Fax / Scan			
Most Responsible Health Practitioner Name	Signature	Date	Time
Witness Name *(to telephone call)*	Signature	Date	Time
Patient Interpretation Declaration			
Obtaining Consent with Assistance of interpretation I acknowledge I have interpreted the information given to me about the treatment plan or procedure and the content of this consent form to the person giving consent and I believe to the best of my ability that the person understands the information.			
Interpreter Name *(print)*	Signature of "by telephone"	Date	Time
Emergency Treatment			
☐ Emergency Treatment was provided	Signature of Healthcare Practitioner Signature of supporting Healthcare Practitioner	Date	
Withdrawal of Consent			
☐ I withdraw my consent for the entire treatment plan or procedure as detailed on Page 1. The risks and consequences of my withdrawal have been explained to me. ☐ I withdraw my consent for the following specific portions of the treatment plan or procedure. _____ The risks and consequences of my withdrawal have been explained to me.			
Name of person withdrawing consent	Signature	Date	Time
Note: Health Practitioner documenting the withdrawal of consent should inform the Most Responsible Health Practitioner of the withdrawal of consent to the treatment plan or procedure.			