❑RUH ❑SCH ❑ SPH

OTHER _____

Addressograph / Label

NAME: _____

HSN: _____

D.O.B.: _____

CONSENT TO SURGERY
DIAGNOSTIC & TREATMENT PROCEDURES

1. I, _____ consent to and authorize Dr. _____
   (Name of patient or guardian)

   and/or such assistants as may be selected by the physician/dentist, to perform the following procedure(s) on _____. Procedure(s):_____
   (Name of patient or MYSELF)

   _____

   _____

2. The procedure(s) listed in paragraph 1 have been explained to me and I understand the nature of the procedure(s).
3. I recognize that, during the procedure(s), unforeseen or unknown conditions may require additional or different procedures than those described in paragraph 1. I therefore further authorize and request that the above named physician/dentist, his/her assistants, or his/her designate perform such procedures as are in his/her professional judgement, immediately necessary and desirable, and such that delay is not feasible and would endanger my life or health.
4. I consent to the administration of an appropriate anaesthetic.
5. I acknowledge that no guarantees have been made to me as to the results of the procedure(s).
6. I agree to the retention of any tissue that may be removed during the procedure(s) for diagnosis, study for quality assurance or improvement purposes, and the disposal of any removed tissue according to approved SHR/SPH practice.
7. I acknowledge that this is a teaching facility and that my physician/dentist may allow professional trainees to participate in the procedure(s) under supervision.
8. In the event a health care worker is exposed to my blood or body fluids, I consent to being tested for blood borne pathogens (e.g., HIV, Hepatitis B & C, etc.). I understand that the results of the test will be used to provide appropriate treatment for the health care worker. In the event of a positive result, I will be contacted by the appropriate healthcare personnel and offered follow up treatment. I also understand that the Saskatoon Health Region is obligated by law to inform Public Health Services in the event of a positive result for the purposes of providing appropriate follow up.
9. _____ _____
   (Signature of patient or guardian) (Date)

CERTIFICATION BY THE PHYSICIAN/DENTIST OBTAINING CONSENT

10. I hereby certify that the nature, effect, risks and alternatives of the procedure(s) named in paragraph 1 have been explained to the above named patient or guardian who has consented to it.

    _____ _____
    (Signature of physician/dentist obtaining consent) (Date)

See Reverse Side for Facsimile, Letter or Telephone Use; For Use in an Emergency Situation When Unable to Obtain Consent, or for a Mentally Incompetent Adult; Certification by Interpreter; and treatment for Non-Canadian Residents

Indicate below the method of receiving consent, if received by facsimile, letter or telephone. In case of letter or facsimile please attach. In case of telephone consent, there should be two witnesses' signatures obtained below, one of whom shall be a physician/dentist.

Consent Received by: ❑ Letter ❑ Facsimile ❑ Telephone

From: (name) _____ Relationship to patient: _____

Witness: Witness: (Physician)

A. For use when unable to obtain consent in emergency situations,

A. I certify that delay in doing this procedure will seriously endanger the health or life of the patient.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

B. For use when a mentally incompetent adult patient without a guardian is in need of treatment.

B. I certify that this patient, who is a mentally incompetent adult, is in need of treatment and to my knowledge has not previously withheld consent to this treatment. This treatment is necessary and in the best interests of this patient. To my knowledge, this patient does not have a legal guardian.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

CERTIFICATION BY INTERPRETER

I hereby certify that I was present and interpreted the consent obtained by Dr. _____ who explained the procedure(s) described in paragraph 1 on reverse.

_____ _____
(Signature of Interpreter) (Date)

TREATMENT FOR NON-CANADIAN RESIDENTS

The patient acknowledges that the treatment/service was performed in the Province of Saskatchewan and that the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient or Guardian) (Date)