FIVE HILLS HEALTH REGION
Consent to Investigation, Treatment, or Operative Procedure

I,_____,
(name of patient, parent or legal representative)

hereby consent to the following investigation, treatment , or operative procedure:

_____
(name of procedure where applicable)

to be performed upon _____,
(myself or name of patient)

Personal Health No,: _____
(PHN)

by _____.
(doctor/treatment provider)

The nature and anticipated effect of what is proposed, including the significant risks and available alternatives have been explained to me by the above-named physician. I am satisfied with these explanations and understand them. I also understand that in all medical and surgical procedures there are rare complications that cannot be anticipated. I also consent to such additional or alternative investigations, treatments or operative procedures as are immediately necessary in unforeseen circumstances.

I further agree that in his or her discretion, the physician named above may make use of the assistance of other surgeons, physicians and hospital medical staff and may permit them to order or perform all or part of the investigation, treatment or operative procedure, and they shall have the same discretion in my/his/her investigation and treatment.

I also request and consent to the administration of such local or general anaesthesia as may be deemed advisable by my physician/anaesthetist and/or their assistants.

I agree that any tissue removed from my/his/her body may be retained by the institution for diagnostic research and/or educational purposes unless I otherwise specify.

Based on the foregoing, I freely give my authorization for the above.

_____
Patient, Parent or Legal Representative Signature

_____ _____
Witness Date

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CONSENT RECEIVED BY TELEPHONE, LETTER OR FAX

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

Consent received via: □ □ Letter
□ □ Fax
□ □ Telephone

From _____ (name)

Relationship to Patient _____

_____
Date

_____ _____
Physician Witness

THE HEALTH CARE DIRECTIVES AND SUBSTITUTE HEALTH CARE DECISION MAKERS ACT

□ □ There is no nearest relative, proxy or personal guardian.

□ □ A reasonable attempt has been made to locate the nearest relative, proxy or personal guardian but one cannot be found.

_____
Date

_____ _____
Physician's Signature Second Physician's Signature