fraserhealth

Regional
CONSENT FOR HEALTH CARE

Form ID: CWXX104852B Rev: March 30, 2022

Patient Last Name	Patient First Name	Other Names	Date of Birth *(dd/mm/yyyy)*	Personal Health Number (PHN)
			/ /	

Section 1: Health Care Provider[1] Statement

Details of proposed health care *(print legibly, in full without abbreviations, and use plain language).*

☐ I discussed the proposed health care and related risks with the patient or substitute decision-maker. I confirmed their understanding by asking them to explain it in their own words. I feel confident they understood the information provided.

Provider Name *(print):* _____ Signature: _____ Date *(dd/mm/yyyy):* / /

[1] Note: Health Care Provider: licensed, certified, or registered to provide health care and who is responsible for the patient's care (usually a physician or nurse practitioner)

Section 2: Patient or Substitute Decision-Maker Consent

I have the right to decide whether to accept the proposed health care.

I also have the right to change my mind any time, even after signing this form.

My health care provider explained the following about the proposed health care: what it is; why it is needed; how it might benefit me; what risks and side effects are possible; what other choices I have; and what might happen if I do not have the health care. I had a chance to ask questions and I understood the answers given. I have all the information I need to decide.

Also, I understand and agree to the following:

a. Before the health care starts, my health care provider can do all the procedures needed.
b. During my health care, my health care provider can do necessary medical procedures connected to the health care.
c. My health care provider might allow other health care providers (including trainees) to observe or take part in my health care. My health care provider will direct or oversee these other health care providers.
d. If my health care involves removing tissues, body fluids, or implants, my health care provider could send it to the laboratory for further study. It might also be used for teaching or research purposes in accordance with privacy laws.
e. If my health care involves putting in a medical device, my health care provider shares my personal information with the supplier of the device for my safety. The sharing of my information comes under the privacy laws of the country where the supplier is located.
f. If a health care worker is exposed to my blood or body fluids by accident, my blood will be tested for Hepatitis B, Hepatitis C, and HIV. If any of these are found, I will be offered treatment. Also, public health is told as required by law (Public Health Act). My test results will be used to guide treatment for the health care worker.

I , _____ *(print name),* consent to the proposed health care as described in Section 1 above.

Signature: _____ Date *(dd/mm/yyyy):* / /

☐ Patient ☐ Parent / Legal Guardian ☐ Substitute Decision-Maker[2]

[2] Note: If signed by Substitute Decision-Maker, complete the Regional Confirmation of Substitute Decision-Maker Form (ADDI102738).

Section 3: Administration of Blood Components or Products (if applicable) ☐ Not applicable

My health care provider told me they might need to give me blood components or blood products during my health care.

My health care provider also explained the risks, benefits, and available alternatives to transfusion.

☐ Yes, I consent to receive blood components or products ☐ No, I refuse blood components or products[3]

Signature: _____ Date *(dd/mm/yyyy):* / /

☐ Patient ☐ Parent / Legal Guardian ☐ Substitute Decision-Maker

[3] Note: If consent refused, complete the Refusal of Blood Components/Products Administration Form (CWXX100106).

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Section 4: Interpreter Declaration

☐ I have accurately interpreted the explanation of the consent by the health care provider to the patient or substitute decision-maker. This person told me that they understand the explanation and consents as described on Page 1 of this form.

Interpreter Name *(print)*: _____ Signature: _____ Date *(dd/mm/yyyy)*: ___/___/___

Section 5: Virtual Consent

A. Consent from Patient

☐ I discussed the nature and expected effects of the proposed health care, including significant risks and available alternatives, with the patient _____*(print name)*. The patient gave their verbal consent to proceed with the proposed health care.

☐ N/A I explained to the patient that it may be necessary for them to receive **blood components or blood products** during their proposed health care.

☐ Yes, patient consented to the receipt of blood components/products ☐ No, the patient refused

☐ I have informed the patient they will need to sign Section 2, and if applicable, Section 3 of this Form when they appear for their health care.

Provider Name *(print)*: _____ Signature: _____ Date *(dd/mm/yyyy)*: ___/___/___

Note: The health care provider should check the appropriate box concerning the administration of blood products and explain to patient they still need to complete and sign Section 2 and 3 of this Form.

B. Consent from Substitute Decision-Maker (SDM)

☐ I discussed the nature and effects of the proposed health care, including significant risks and available alternatives with _____*(print name)*, who is the patient's _____*(state relationship), and* who has given verbal consent as SDM.

☐ N/A I explained to the SDM that it may be necessary for the patient to receive **blood components or blood products** during their proposed health care.

☐ Yes, SDM consented to the patient receiving blood components/products ☐ No, the SDM refused

Provider Name *(print)*: _____ Signature: _____ Date *(dd/mm/yyyy)*: ___/___/___

Note: The health provider should check the appropriate box concerning the administration of blood products. Where possible, the SDM should sign Section 2, and if applicable, Section 3 of this form at the earliest opportunity.

Section 6: Certificate of Need for Urgent/Emergency Health Care

☐ I certify that it is necessary to provide the proposed health care without delay in order to save the patient's life, to prevent serious physical or mental harm, or to alleviate severe pain. The patient is, in my opinion, incapable of giving or refusing consent, and has not previously indicated a refusal to consent to this health care. I have been unable to consult with any available substitute decision-maker within a reasonable time in the circumstance and am not aware of an Advance Directive that the patient does not want the proposed health care.

Provider Name *(print)*: _____ Signature: _____ Date *(dd/mm/yyyy)*: ___/___/___

If practicable, it is recommended a second provider confirm the need for the proposed health care and the patient's incapability.

Provider Name *(print)*: _____ Signature: _____ Date *(dd/mm/yyyy)*: ___/___/___

Instructions to Providers:

1. To be completed and signed in ink.
2. After health care provider obtains virtual consent from the patient or substitute decision-maker, nursing or allied health staff may obtain patient or substitute decision-maker signature as confirmation of the consent decision. Any explanation of the proposed health care is the health care provider's ultimate responsibility.
3. Section 3 to be completed only if applicable.
4. The health care provider and the patient or substitute decision-maker must initial and date any changes made to this form.
5. The signed form must be placed on the patient's health record.