fraserhealth

# Regional
# CONSENT FOR HEALTH CARE

CWXX104852A Rev: June 2011 

| PATIENT SURNAME | FIRST NAME | Other names | DOB(d/m/yyyy) | CARE CARD # |
|---|---|---|---|---|
| | | | | |

## Section 1: Provider* Statement

Details of proposed health care treatment, procedure or treatment plan ***(print legibly and in full without abbreviations):***

_____

_____

_____

I have discussed the proposed health care and related risks with the patient or substitute decision-maker who, in my opinion, understood the information provided.

Provider Name (print): _____ Signature: _____ Date (d/m/yyyy): _____

***Note: Provider refers to the most responsible health care provider proposing and/or performing the health care.***

## Section 2: Patient or Substitute Decision Maker Consent

**Please note:** ***You have the right to ask questions and receive answers about your health care.***

I, _____ consent to the health care described above. The nature and anticipated
(print name)
effect of the proposed care, including the significant risks and available alternatives have been explained to me. I am satisfied with and understand the explanations. I also understand that:

**a.** My provider may make use of other health care providers (including trainees) who may attend and/or assist in my care under the direction of my provider.

**b.** If tissues, body fluids or implants are removed during my care, they may be used for diagnostic examination, education or quality improvement purposes.

**c.** If a health care worker is exposed to my blood or body fluids during my care, my blood will be tested for risk assessment purposes for Hepatitis B, Hepatitis C and HIV. The test results will be confidential and will only be used to treat the health care worker. If positive, the test results will be reported to public health authorities as required by law (*Provincial Health Act*) and I will be offered treatment.

**d.** If my care includes inserting a medical device, my personal information will be shared with the supplier of the device for my safety, and will come under the privacy laws of the country where the supplier is located.

Signature: _____ Date (d/m/yyyy): _____

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

***Note: If signed by Substitute Decision-Maker, complete the Confirmation of Substitute Decision Maker form.***

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

My provider told me it may be necessary for me to receive blood components or blood products during my treatment.

☐ Yes, I consent to receive blood components/products ☐ No, I refuse blood components/products*

Signature: _____ Date (d/m/yyyy): _____

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

***Note:** ***If consent is refused, the Refusal of Blood Components/Products Administration form must be completed.***

Stores # 417470

# Regional
# CONSENT FOR HEALTH CARE Cont'd



**Section 4: Interpreter Declaration**

I have accurately translated this document and acted as interpreter for the patient or substitute decision maker who told me that he/she understands the explanation and consents as described on page 1 of this form.

Interpreter Name (print): _____ Signature: _____ Date (d/m/yyyy): _____

**Section 5: Telephone Consent**

I have discussed the nature and expected 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 substitute decision maker.

Provider Name (print): _____ Signature: _____ Date (d/m/yyyy): _____

***Note: Where possible, at the earliest opportunity, the person who granted consent over the phone should sign Section 2 of this form.***

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

I certify 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 (d/m/yyyy): _____

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

Provider #2 Name (print): _____ Signature: _____ Date (d/m/yyyy): _____

**Instructions to Providers:**

1. To be completed and signed in ink.
2. Nursing staff may obtain the signature of the substitute decision maker following telephone consent as confirmation of the consent decision. Any explanation about the proposed health care is the provider's responsibility.
3. Section 3 to be completed only if applicable.
4. Changes to this form must be initialed and dated by the provider and the patient or substitute decision maker.
5. The original of this form must be placed on the patient's health record.