WEST SHORE MEDICAL LIMITED
CONSENT FORM:
ADULT PATIENT

Name of Patient: ………………………………………………………………..
Name of Practitioner: ……………………………………………………...

Name of proposed examination and procedure or course of treatment (include brief explanation if nature of medical term not clear)……………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

STATEMENT OF PRACTITIONER
INSTRUCTIONS TO PRACTITIONERS: THIS PART OF THE DOCUMENT IS TO BE FILLED OUT COMPLETELY BY YOU BEFORE YOU SIGN IT.

I have explained the proposed examination and procedure or course of treatment to the patient. In particular, I have explained:

The intended benefits ……………………………………………………........................
....
....

Serious or frequently occurring risks ……………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Any extra procedures which may become necessary during the procedure
□ Blood Transfusion
□ Other procedures (please specify) ……………………………………………………….
…………………………………………………………………………………………

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

This procedure will involve:
□ General and/or regional anaesthesia
□ Local anaesthesia
□ Sedation

Signed……………………………………….. Date ..…………………………..…

Name (PRINT) ……………………………… Professional title……………………

STATEMENT OF THE PATIENT
INSTRUCTIONS TO PATIENTS: THIS PART OF THE DOCUMENT IS TO BE FILLED OUT COMPLETELY BY YOU BEFORE YOU SIGN IT.

1. I ______________________ of ____
   ____
   hereby consent to and authorise the proposed examination and procedure or course of treatment stated on this form the nature and purpose of which have been explained to me by the above signing practitioner.

   That Part of this document entitled "Statement of Practitioner" has been completely filled out prior to my signing of this part.

I understand that where I directly engage a practitioner of my own choosing to perform the proposed examination, procedure or course of treatment West Shore Medical is not responsible for such. I further understand that where I engage the services of West Shore Medical (as opposed to a particular practitioner) to perform the proposed examination, procedure or course of treatment, that West Shore Medical is responsible for such

examination, procedure or course of treatment but that West Shore Medical cannot give me any guarantee that a particular practitioner (or particular practitioners) will perform same."

2. The proposed examination and procedure or course of treatment stated on this form has been explained to me and I understand the purpose and nature of the proposed examination and procedure or course of treatment.

3. I also consent to any procedure in addition to or alternative to those described on this form where such is necessary to save my life or to prevent serious harm to my health, and to the administration of general, local or other anaesthetics for any of these purposes.

4. I acknowledge that no guarantee or assurance has been given to me by any of the medical staff of West Shore Medical Centre as to the results which may be obtained by this proposed examination and procedure or course of treatment.

5. I understand that:

    a. Anaesthesia is required for the proposed examination and procedure and that there are risks associated with the administration of anaesthesia that should be explained to me by an Anaesthesiologist or Anaesthetist. I also understand that I should discuss my concerns with my own medical practitioner.

    b. The operating surgeon will be occupied solely with the surgery and that the administration of the anaesthesia is an independent professional function and will be the responsibility of an Anaesthesiologist or Anaesthetist, who is an independent contractor of my choice, from whom I should seek the above explanation of risks, and whom I authorize to administer such anaesthetics that he may deem advisable with the exception of

    ____

    (State "none", "anaesthesia", etc.)

6. I do/do not (delete where inapplicable) agree to receive blood or blood products or derivatives as deemed necessary by the physician testing me.

Patient's signature ………………………........... Date ………………………………...

Name (PRINT) ………………………...

A witness not related to the Patient must sign below

Signature ……………………….......................... Date ………………………………...

Name (PRINT) ………………………...

In the case where the Patient does not understand English a witness not related to the Patient <u>and</u> the Interpreter must sign below to indicate the foregoing consent has been carefully interpreted to the Patient.

Signature of Witness ……………………....................... Date ………………………………...

Name (PRINT) ………………………...

Signature of Interpreter……………….......................... Date ………………………………...

Name (PRINT) ………………………...