CONSENT TO TREATMENT, INVESTIGATIVE PROCEDURE, AND/OR OPERATION

I, ____, consent to the following treatment, investigative procedure,
Name of Patient/Substitute Decision Maker

and/or operation:

Computed tomographic angiography (CTA) with intravenous contrast without creatinine levels

to be performed upon ______________________________ by ______________________________
Name of Patient — Name & Designation of Health Professional

or their designate, and such physicians and other health professionals whose assistance is required.

I acknowledge that the health professional identified above has explained this treatment or procedure:

- its risks and benefits;
- material side effects;
- alternative course of treatment or procedure;
- and consequences of not having or delaying this treatment or procedure.

I have had an opportunity to ask questions and I fully understand all of the information explained.

I consent to such additional alternative treatment, investigative procedure, and/or operation, which in the opinion of the Health Professional performing the procedure(s) are reasonably necessary. I also consent to the administration of anaesthesia for any of these purposes as may be required.

I agree that other members of the medical, midwifery or health professional staff of the Grand River Hospital other than the said Health Professional may perform or assist in treatment, investigative procedure, and/or operation and that others including students under their supervision and direction may assist them as required.

I consent to the administration of blood and/or blood products ______ Yes ______ No
Initials of patient/SDM — Initials of patient/SDM

☐ Health Professional must check box if blood products is not applicable at this time

☐ Name of information sheet provided to patient/SDM: ______________________________

Statement of Declaration

I declare that I fully understand the information provided about the above mentioned treatment, investigative procedure, and/or operation, and the administration of blood/blood products if indicated above.

Date ______________________________ ______________________________
(day / month / year) — Signature of Patient or Substitute Decision Maker

Statement of Health Professional

I declare that I have explained the nature of the treatment, the expected benefits and risks, side effects, the alternative courses of action and the likely consequences of not having the treatment and I have responded to any and all questions about such matters.

Date ______________________________ ______________________________
(day / month / year) — Signature of practitioner proposing treatment

SAMPLE

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SAMPLE

Statement of Witness to Consent by Telephone

I have witnessed over the telephone the consent given to ______________________________
Health Professional Name & Professional Designation

by ______________________________ ______________________ acting as substitute decision maker for
Name of SDM / Relationship to Patient Telephone Number

______________________________ to the above mentioned treatment, investigative procedure,
Name of Patient
and/or operation, and transfusion of blood/blood products if applicable.

Date ______________________________ ______________________________
(day / month / year) Signature and Printed Name of Witness

Interpreter

Interpretation service used ______________________________

Contact information ______________________________ ______________________
Name of Interpreter Telephone Number

Health Professional Statement for Emergency Use

If in the opinion of the Health Professional a delay for the purpose of obtaining consent would put the patient at risk of serious bodily harm or prolonged suffering, the Health Professional should complete the following statement:

I, ______________________________ believe that the delay in obtaining consent to perform
Printed Name & Designation of Health Professional
the treatment, investigative procedure, and/or operation described above would put
______________________________ at risk of bodily harm or prolonged severe suffering.
Name of Patient

Date ______________________________ ______________________________
(day / month / year) Signature of Health Professional

SAMPLE