London Health Sciences Centre

CONSENT TO TREATMENT

[redacted]

SECTION A: Consent for Surgical Operation, Procedure, or Diagnostic Test

I, [redacted], (FULL NAME OF PATIENT OR SUBSTITUTE DECISION MAKER)

the _____ (RELATIONSHIP TO PATIENT) of _____ (NAME OF PATIENT),

have had the nature of the proposed treatment explained to me along with the expected benefits of that treatment. I have been advised of the risks and side effects of the proposed treatment as well as other courses of treatment available to me. I have been informed of the likely consequences of not proceeding with the proposed treatment. I have had the opportunity to ask questions about the proposed treatment and have had my questions answered to my satisfaction. I understand the information provided to me and give consent to the following treatment:

ORTHOTOPIC LIVER TRANSPLANTATION FROM DONOR AFTER CIRCULATORY DEATH DONATION.

(SURGICAL OPERATION, PROCEDURE, OR DIAGNOSTIC TEST)

to be performed by DR DOUGAY QUAN (FULL NAME OF HEALTH PRACTITIONER) and his/her team.

I understand that any tissues/organs removed during care may be retained and used for the purposes of diagnostic examination, education or research and will be disposed of by the hospital based on standards governing the disposal of such material.

I also understand that if a health care provider 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 only be used to treat the health care provider. If positive, the test results will be reported to public health authorities as required by law and I will be offered treatment.

Date: 2020/11/01 (YYYY/MM/DD) [redacted] (SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER)

SECTION B: Consent for Transfusion of Blood and/or Blood Products ☐ Not Applicable

I have been given information on the transfusion of blood and/or blood products and had an opportunity to discuss available alternatives, risks and benefits.

☑ I **consent** to the transfusion of blood and/or blood products if required.

☐ I **refuse** the transfusion of blood and/or blood products and have completed a Refusal/Consent with Restrictions of Blood and/or Blood Products Form (NS5646) or, if applicable, Letter of Understanding for Patients Under 16 Years of Age.

Date: 2020/11/01 (YYYY/MM/DD) [redacted] (SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER)

SECTION C: Consent for Photography, Video and Audio Recording ☐ Not Applicable

I have been informed of the purpose(s) of photography/recording.

☑ I **consent** to: ☐ Photography ☐ Video Streaming ☐ Video Recording ☐ Audio Recording
for the purpose(s) of: ☐ Patient Care ☐ Education ☐ Quality Assurance

☐ I **refuse** photography, video and audio recording for the purposes of patient care, education and/or quality assurance.

I understand that video surveillance is conducted in designated areas of the hospital to ensure the safety of patients, visitors, staff and affiliates, and that signage is posted to identify where video surveillance is in effect.

Date: 2020/11/01 (YYYY/MM/DD) [redacted] (SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER)

SECTION D: Health Practitioner Statement

I, QUNKA QUAN [signature] (FULL NAME OF HEALTH PRACTITIONER) am the health practitioner proposing and/or performing the treatment noted above. I have explained the nature of the treatment, the expected benefits, risks and side effects, alternative courses of treatment and the likely consequences of not proceeding with the proposed treatment to the patient/substitute decision maker. I have answered the questions of the patient/substitute decision maker to the best of my ability. To the best of my knowledge, the patient/substitute decision maker is giving his or her informed consent to the proposed treatment voluntarily.

Date: 2020/11/01 (YYYY/MM/DD) [signature] (SIGNATURE OF HEALTH PRACTITIONER PROPOSING/PERFORMING TREATMENT AND OBTAINING INFORMED CONSENT FROM THE PATIENT/SUBSTITUTE DECISION MAKER)