St. Joseph's Healthcare Hamilton

CONSENT TO TREATMENT

I, _____ hereby consent to the following treatment, investigative
(Print Name of Patient or Substitute Decision Maker)

procedure or operation: Jejunostomy
(Print and include the site, side and level if applicable. Do not abbreviate.)

to be performed upon _____ by Dr. R. Spaziani, or their delegate and by
(Print Name of Patient) (Print Name and Designation of Health Practitioner)

other physicians and health practitioners whose assistance he/she requires. If there are any unexpected conditions or problems during treatment, I consent to such additional treatments which in the opinion of the Health Practitioner performing the procedure(s) may be necessary to maintain my life.

I consent to the administration of anesthetic medication by or under the supervision of a member of the medical staff who has privileges at St. Joseph's Healthcare Hamilton.

I acknowledge that the Health Practitioner has explained the nature of the above treatment or procedure, its expected benefits, material risks and side-effects, alternative courses of action and the likely consequences of not having this treatment.

I understand that St. Joseph's Healthcare Hamilton (SJHH) is a teaching hospital and agree to have supervised health practitioners-in-training participate in my treatment and care.

I give consent to the videotaping, photography and use of other images for teaching and research purposes. I understand that if any such images can identify me, my expressed consent will be obtained prior to using such images for external teaching or research purposes. yes_____(initials) / no_____(initials)

I have had the opportunity to ask questions about the proposed treatment and have had my questions answered to my satisfaction. I [illegible] have read this form and understand it.

_____ _____
Signature of Patient Print Name of Patient

_____ _____
Signature of Substitute Decision Maker Print Name of Substitute Decision Maker

_____ 2020/09/11
Relationship to Patient Date (yyyy/mm/dd)

STATEMENT BY HEALTH PRACTITIONER

I declare that I have explained the nature of the treatment, procedure or operation, its expected benefits, material risks and side effects, alternative courses of action, the likely consequences of not having the treatment and answered all related questions to the Patient and/or Patient's Substitute Decision Maker.

_____ _____ 2020/09/11
Signature of Health Practitioner Print Name of Health Practitioner Date (yyyy/mm/dd)

ADMINISTRATION OF BLOOD/BLOOD PRODUCTS

I acknowledge that the Health Practitioner has explained the nature of a blood transfusion(s) and/or administration of blood/blood products, the expected benefits, material risks and side-effects, alternative courses of action and the likely consequences of not having this treatment. I understand this information provided to me and the answers I received to my questions.

CONSENT FOR BLOOD or BLOOD PRODUCTS

I agree to the administration of blood or blood products during the course of my treatment.

Date (yyyy/mm/dd) Signature of Patient/Substitute Decision Maker

REFUSAL OF BLOOD or BLOOD PRODUCTS

I hereby refuse consent to the administration of blood or blood products and release and hold harmless the Health Practitioner(s), Hospital and its employees from any liability resulting from the failure to administer or continue to administer blood or blood product(s).

Date (yyyy/mm/dd) Signature of Patient/Substitute Decision Maker