CONSENT TO TREATMENT (PHC)

* 2 7 4 5 *

Consent Procedure

I hereby authorize R. KAVIANI M.D./D.D.S./_____ and such physicians, surgeons, anesthetists and hospital staff whose assistance is required, to perform the following test(s), treatment(s), procedure(s) and/or operation(s):

CAST REPORT

The nature and possible effects, including the significant risks and alternatives to this test, treatment or operation, have been explained to me and I understand the explanation and the alternatives.

If unexpected conditions are discovered during the above test, treatment or operation, I consent to such additional or alternative tests, treatments or operations as the health care provider named above finds immediately necessary.

I also agree to receive anaesthesia and such anaesthetics as may be considered necessary. I understand that it is my responsibility to refrain from driving a motor vehicle for 24 hours following my anaesthetic and to have a responsible adult accompany me home.

I understand that Providence Health Care participates in medical education and quality improvement and as a result I agree that:

1. supervised health practitioners-in-training who are in approved education programs may participate in my care;
2. tissues, bodily fluids, devices or implants removed in this procedure become the property of the hospital and may be used for such purposes, including teaching or research, as is approved by the hospital; and
3. my doctor or dentist may give information to the hospital about follow-up care in my doctor or dentist's office.

I understand that if I receive an implant/tissue from a source outside of Canada, Providence Health Care is required to provide information about me - including my name, address and the fact that I have this implant - to the provider of that implant/tissue so that I may be notified of any issues which arise about the device that could affect my health and safety. I further understand that it is possible that my personal information stored by the provider of the implant/tissue may be accessed by the government of that country without my knowledge or consent pursuant to applicable legislation. I authorize Providence Health Care to disclose my personal information to the provider of the implanted device or tissue as reasonably required.

X verbal consent provide. May 4 /2022.

Signature of patient — Date & time of signature

Signature of Substitute Decision Maker (Form 2760 must be completed) — PRINT NAME

Signature of M.D./D.D.S. _____ obtaining consent — PRINT NAME

Witness signature (when MD not present at time of signing) — PRINT NAME