☐ Civic ☐ General ☐ Riverside ☐ TRC ☐ CC

[redacted]

CONSENT TO TREATMENT

I, ______________________ agree to have the treatment/operation/procedure:
Patient name/Substitute decision maker (SDM)

Right Clavicle open reduction internal fixation + decompression brachial plexus

to be done by (Health Practitioner) Drs Liew/[illegible]/[illegible]/[illegible]/Pollock/Alzahrani, and will allow:

- Anesthetics, other medications and/or blood products, if needed;
- Any other treatment, operations and procedures needed in an emergency;
- The Health Practitioner to use the help of other Health Practitioners, including residents and students;
- The disposal of any tissue or parts that have been removed during the treatment/operation/procedure;
- Devices/medical products implanted during procedures may be registered with the corresponding vendor for quality control.

I confirm that (Health Practitioner) [redacted]

- Has explained the treatment/operation/procedure to me, and the risks, side effects and expected benefits of the treatment/operation/procedure;
- Has answered my questions about the treatment/operation/procedure;
- Has told me about other possible treatments; and
- Has told me about the possible effects if the treatment/operation/procedure is not done.

I **understand these explanations and I am satisfied with them.**

Initial	CONSENT TO COLLECTION OF SURPLUS TISSUE FOR RESEARCH
	I voluntarily agree to have surplus tissue made available to researchers after my surgery for use in research ethics board approved research projects.
	I refuse to have surplus tissue made available to researchers after my surgery.
	Not applicable (any surgeries where no tissues will be removed).

I have received, read and understood the patient information page describing global tissue collection project.

Patient or [redacted] (SDM)	Signature	Date (yyyy/mm/dd)
X		2023 [illegible]