Providence Health Care

Place Patient Label Here

PHC&VCH CONSENT FOR HEALTH CARE

CONSENT PROCEDURE

			DD / MMM / YYYY	
Patient Last Name	Patient First Name	Other Names	Date of Birth	Personal Health Number (PHN)

Section 1: Proposed Health Care

Details of proposed health care *(if extra space is needed, please add that information on a separate page and attach it to this form)*.

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Patient or Substitute Decision Maker

- I have the right to decide whether to accept the proposed health care, and I have the right to change my mind at any time, even after signing.
- My Health Care Provider explained the following about the proposed health care:
  - a. What it is,
  - b. Why it is needed and how it might benefit me,
  - c. The likelihood of the health care succeeding,
  - d. What risks and side effects are possible,
  - e. What other choices I have, and
  - f. What might happen if I do not have the health care.
- I had a chance to ask questions, and I understood the answers given. I have all the information I need to decide whether to accept the health care.
- I understand and agree to the following:
  - a. During my procedure, if an issue that needs immediate addressing is discovered and I am not able to consent, my Health Care Provider may perform additional procedures required to address that issue.
  - b. Other Health Care Providers (including trainees) may take part in my health care and will be directed or overseen by my Health Care Provider.
  - c. As the facility is a teaching environment, students or trainees may observe my procedure unless I say no.
  - d. My Health Care Provider may send removed tissue, body fluids, or implants to the laboratory for study and/or use it for teaching or research purposes in accordance with privacy laws.
  - e. If a medical device is inserted, for my safety, my personal information will be shared with the device's supplier.
  - f. If a health care worker is exposed to my blood or bodily fluids, I will be tested for certain blood borne illnesses including Hepatitis and HIV. Positive results will be reported to Public Health if required.
  - g. If I am consenting as a Substitute Decision Maker I must communicate with the patient regarding their wishes and make decisions according to their prior known capable wishes, or if unknown, in their best interest.

I, ________________________ (print name), consent to the proposed health care as described in Section 1.

Note: If virtual or telephone consent was obtained originally, the patient must be asked to sign this form when they arrive on site for health care.

Signature: ______________________________ Date: ______________

☐ Patient ☐ Parent/Legal Guardian ☐ Substitute Decision Maker DD / MMM / YYYY

Health Care Provider: ____________________ ____________________ Date: ______________

Printed Name Signature DD / MMM / YYYY

I interpreted this form for: ____________________ Name of interpreter: ____________________

The Patient, Parent, Legal Guardian or Substitute Decision Maker may provide consent verbally or imply consent through their actions. The patient must not be denied health care treatment strictly because no one can or will sign this form.

If consent was verbal or inferred, print the name of the Health Care Provider who received the consent: ____________________ ➔ Section 2 Page 2

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NOTE: "Patient" refers to an individual receiving services through Vancouver Coastal Health or Providence Health Care and includes clients and residents across acute, community and long term care settings.

Section 2: Certificate of Need for Urgent/Emergency Health Care
(Complete section 2 if providing Urgent/Emergency Health Care without consent)

Details of proposed health care *(if extra space is needed, please add that information on a separate page and attach it to this form).*

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☐ I certify that it is necessary to provide the proposed health care without delay in order to save the patient's life, to prevent serious physical or mental harm, or to alleviate severe pain. The patient is, in my opinion, incapable of giving or refusing consent, and has not previously indicated a refusal to consent to this health care. I have been unable to consult with any available Legal Guardian or Substitute Decision Maker within a reasonable time in the circumstances and am not aware of an Advance Directive that the patient does not want the proposed health care.

Health Care Provider (MD or NP): ____________________ ____________________ Date: ______________
Printed Name Signature DD / MMM / YYYY

If practical, it is recommended a second provider confirm the need for the proposed health care and patients incapability

Health Care Provider (MD or NP): ____________________ ____________________ Date: ______________
Printed Name Signature DD / MMM / YYYY

Section 3: Administration of Blood, Blood Components, or Blood Products (if applicable) ☐ Not applicable

- My Health Care Provider told me they might need to give me blood, blood components, or blood products during my health care
- My Health Care Provider has explained the risks, benefits, available alternatives, and possible consequences of accepting or refusing blood, blood components, or blood products.

☐ Yes, I consent to the transfusion of blood, blood components, and blood products

☐ Yes, I consent to the transfusion of only the following blood products:

Accepted Products: ____

☐ No, I refuse consent to the transfusion of blood, blood components, and blood products. I confirm that my decision is free and informed and that I assume responsibility for the consequences of my decision.

Printed Name and Signature: ________________________________ Date: ______________
☐ Patient ☐ Parent/Legal Guardian ☐ Substitute Decision Maker DD / MMM / YYYY