Interior Health

PATIENT CONSENT RECORD
APPRECIABLE RISK PROCEDURES

(Surgery / Blood Transfusions / Labour & Delivery or other procedures with Appreciable Risk of Harm as determined by the Prescribing Practitioner)

Section A: PATIENT INFORMATION *(to be completed by Physician or other Prescribing / Offering Practitioner)*

Re: _____ PHN # _____ DOB _____
(Print name of patient)

The above noted patient requires the following healthcare:

(a) _____

(b) _____

Please provide sufficient detail including a series of treatment / procedures if required

Section B: CONSENT DOCUMENTATION *(to be completed by Physician or other Prescribing / Offering Practitioner)*

I have reviewed with the: ☐ Patient ☐ Committee of Person / Personal Guardian ☐ Representative
☐ Temporary Substitute Decision Maker (TSDM) ☐ Legal Guardian of Person Under 19

Name of Committee / Representative / TSDM / /Legal Guardian: _____
(please print)

☐ the patient's diagnosis,
☐ the alternatives, benefits and risks of the above named procedure(s) as it relates to the patient's diagnosis, and
☐ the patient / substitute decision maker / legal guardian indicated that he / she understood the information and that it applied to the patient's diagnosis,
☐ that the use of blood / blood products / human tissue is not applicable, **OR**
☐ that blood / blood products / human tissue will possibly be required and the alternatives, benefits and risks of blood / blood products / human tissue. The patient / substitute decision maker / legal guardian:
CONSENTS to the use of ☐ blood ☐ blood products ☐ human tissue *(specify _____)*, **OR**
REFUSES the use of ☐ blood ☐ blood products ☐ human tissue *(specify _____)*
☐ the patient / substitute decision maker / legal guardian has been given the opportunity to ask questions about the procedure(s) and the benefits and risks of blood / blood products / human tissue (if applicable).
☐ that the patient / substitute decision maker / legal guardian has been apprised of the fact that blood and / or tissue procured during the procedure, if any, may be used for quality or other academic purposes.
☐ that supervised health practitioners-in-training who are in approved education programs may participate in the patient's care.

The foregoing information was provided: ☐ in person **OR** ☐ by telephone

_____ _____ _____
Practioner Name (please print) Signature Date *(dd/mm/yyyy)*

Optional: I, the person signing below, confirm I have been provided with the above information and have given my consent to the indicated healthcare.
Signature: _____ Date: *(dd/mm/yyyy)* _____

Section C: CONFIRMATION OF CONSENT *(to be completed by the Nurse or other Licensed / Registered Health Care Provider (HCP) who is not the prescribing / offering practitioner)*

I have asked the: ☐ Patient ☐ Committee of Person / Personal Guardian ☐ Representative
☐ Temporary Substitute Decision Maker (TSDM) ☐ Legal Guardian of Person Under 19

Name of Committee / Representative / TSDM / /Legal Guardian: _____
(please print)

1. Has the doctor / practitioner given you enough information for you to consent to the procedure(s) / treatment(s) as written above?
2. Have you consented to the procedure(s) / treatment(s) (including, if applicable, the transfusion of blood or blood products) as explained to you by your doctor / prescribing practitioner?

If the reply to question 1 **OR** 2 is **NO**, refer the client back to doctor / practitioner and document details in the client chart.
Only proceed if the above named person answers yes to both questions 1 & 2

☐ Above named person has confirmed consent. **Do not sign next line until the answer to questions 1 and 2 is YES**.

_____ _____ _____
Health Care Provider Name (please print) Signature Date *(dd/mm/yyyy)*

Section D: WITNESSING to TELEPHONE CONSENT *(to be completed by the witness if practicable)*

I, the undersigned, witnessed the telephone conversation and consent given therein between the patient (or the patient's substitute decision maker) and the physician named above.

Name (please print)	Signature	Date *(dd/mm/yyyy)*

Section E: CAPABLE PERSONS UNDER 19 *(to be completed by the Prescribing / Offering Practitioner when applicable)*

I have discussed with the patient whether to release information about the above noted healthcare to his / her parents / legal guardian and have been advised to:

- ☐ not disclose information about the his / her health care, **OR**
- ☐ disclose information about his / her health care.

Name (please print)	Signature	Date *(dd/mm/yyyy)*

Section F: INCAPABLE PATIENT REQUIRING EMERGENCY CARE WITHOUT A COMMITTEE, REPRESENTATIVE OR LEGAL GUARDIAN *(to be completed by the Prescribing / Offering Practitioner)*

I have examined the above named patient and it is my opinion that:

- ☐ it is necessary to provide the above noted health care without delay in order to preserve the patient's life, to prevent serious physical or mental harm or to alleviate severe pain, and
- ☐ the patient is not capable of giving or refusing consent, and
- ☐ I am not aware that the patient has previously indicated a refusal to consent to this health care, and
- ☐ I have made reasonable attempts to find out if the patient has committee of person, a representative, or in the case of a person under 19, a legal guardian and have been unable to identify if such a substitute decision-maker exists, **OR**
- ☐ I understand that a legal guardian of person under 19, committee of person or a representative exists but, despite reasonable attempts, I have been unable to communicate with this person.

Most Responsible Physician:

Name (please print)	Signature	Date *(dd/mm/yyyy)*	Time

Second Physician: (if **practicable** confirm the need for the proposed health care and the patient's incapability)

Name (please print)	Signature	Date *(dd/mm/yyyy)*	Time

Section G: INTERPRETER *(to be completed by the Prescribing / Offering Practitioner if required)*

I have provided the information contained in this form (Section B) to:

_____, an interpreter, a family member, or friend who has
(Print name of person)

advised me he / she has translated the information to the patient and the patient has given his / her consent to the proposed health care.

Name (please print)	Signature	Date *(dd/mm/yyyy)*