STATEMENT OF INFORMED CONSENT

841270

TREATMENT / TEST / OPERATION: Cataract Extraction and IOL Implant

(NO ABBREVIATIONS TO BE USED)

CONSENT STATEMENT:

I understand:

- The anticipated nature, benefits, risks and side effects of the above treatment / test / operation.
- The anticipated nature, benefits, risks and side effects of any alternative courses of action and likely consequences of not having the treatment / test / operation;
- That other qualified individuals may assist in the treatment / test / operation.

I have had the opportunity to ask questions, and any questions I have asked have been answered to my satisfaction. I consent to this treatment / test / operation.

X

Signature of Patient//Substitute Decision Maker (SDM) Print Name Date

If signed by SDM, state relationship to patient

Signature of Translator (if required) Print Translator's name

BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS

I consent to receive donor blood and/or blood products manufactured from donor blood.

I acknowledge that the benefits and risks of receiving a donated unit of blood including blood products manufactured from donor blood have been discussed with me and all questions have been answered to my satisfaction

Signature of Patient//Substitute Decision Maker (SDM) Print Name Date

If signed by SDM, state relationship to patient

Signature of Translator (if required) Print Translator's name

PHYSICIAN / DENTIST / MIDWIFE OR ALLIED HEALTH PROFESSIONAL PERFORMING DELEGATED MEDICAL ACTS STATEMENT:

I have explained the anticipated nature, material risk and side effects, any alternative course of action, likey consequesces of not having the above treatment / test / operation, that other qualified individuals may assist in the treatment and have responded to questions or concerns of the patient / SDM.

Signature Print Name Ying Lu Date

Distribution: Chart Copy

STATEMENT OF INFORMED CONSENT

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TREATMENT IN EMERGENCY WITHOUT CONSENT

I am of the opinion that the patient is in a life or health threatening situation requiring immediate treatment. The patient is not capable of giving consent and it is not reasonably possible to obtain consent or refusal on the patient's behalf and there is no knowledge of a prior refusal.

____
Name of Practitioner (please print)

______________________________ ______________________________
Signature of Practitioner Date

FOREIGN RESIDENTS AGREEMENT

Governing Law and Jurisdiction Agreement
(for Health Care Organization)

Governing Law
I hereby agree that:

a) all aspects of the relationship between me and the Scarborough Health Network (as well as its agents, delegates, employees and any physicians and other independent health care practitioners providing medical or other health care and treatment to me at or in association with the Scarborough Health Network), including without limitation any medical or other health care and treatment provided to me, and
b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this agreement,
shall be governed by and construed in accordance with the laws of the Province or Territory of Ontario and the laws of Canada applicable therein.

Jurisdiction

I heareby acknowledge that the medical or other health care and treatment I receive from The Scarborugh Health Network will be provided in the Province or Territory of Ontario, and that the Courts of the Province or Territory of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding, or cause of action, whatsoever, arising from or in connection with that medical or other health care and treatment, or from any other aspect of my relationship to the Scarborough Health Network.

______________________________ ______________________________ ______________
Signature of Patient//Substitute Decision Maker (SDM) Print Name Date

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If signed by SDM, state relationship to patient

______________________________ ______________________________
Signature of Translator (if required) Print Translator's name