

ACH	PLC	
CBVCC	RGH	
FMC	Other	

Admission, Assessment, Treatment and/or Specific Procedure Consent

☐ Inpatient	□ O ₁	utpatient	☐ Day Procedure	· · · · · · · · · · · · · · · · · · ·						
	g/Responsible Physician (please prin		,							
		on behalf of		consent to:						
ι,	(print name)		(print name)	consent to.						
(a) admission, inv	estigation, assessment or treatmen	nt as may be deemed med	dically necessary and that Calgary Hea	alth Region medical staff						
	_		others in training) will perform such	_						
or body fluid, treatment of t required by th	blood testing for blood-borne viruses, Hepatitis B, Hepatitis C and HIV, in the event that a health care worker is exposed to my blood or body fluid, provided that the results of this testing will be kept confidential and will be used only for the purpose of diagnosis and treatment of that health care worker. If positive, my results will be reported to the Calgary Health Region Medical Officer of Health as required by the Public Health Act and treatment will be offered;									
• •	t is removed during the procedure	(s) may be retained for e	education and/or research;							
(e) the administra	esthetics if medically necessary; ation of blood and/or blood produ	cts if medically necessary								
I understand										
	=		ent or accept recommendations for tr ny personal belongings and I release t							
	n whatsoever with respect to loss			ne Caigary Fleatur Region						
•			may not be covered, or may exceed	my plan benefits. Laccept						
	for payment of any additional char		may not be covered, or may exceed	my plan belienes. Taccope						
Signature of ☐ Pa	· · · · · · · · · · · · · · · · · · ·	8	Date	Time						
or □ Le	gal Representative		(YYYY/MM/I	DD)						
Signature of Witne	ess	Witness	Printed Name							
_										
Section II - C	Consent for Specific Proce	edure (to be complete	od by physician)							
			o by projection,							
alternatives available	le, have been explained to me by D	Dr	c procedure(s) outlined below, includ	ing the significant risks and						
and I am satisfied v	with, and understand the information	on provided to me.								
Procedure(s) (wi	rite in full without abbreviations, p	referably in layman's lang	guage):							
Signature of D Pa	tient		Date	Time						
or □ Le	gal Representative		(YYYY/MM/I	DD)						
Signature of Witne	ess	Witness	Printed Name							
•	rtification Statement									
		edure(s) to the above nar	med patient/legal representative who,	in my opinion,						
	ature, risks and consequences.			T:						
Signature of Physic	nan		Date	Time						

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Alternate Consent	For		Section I	and/or		Section II		
☐ Consent has been received, but unable to obtain signature because:								
OR								
□ Telephone								
□ Fax								
□ Other								
Name:								
Legal Status to Patient: Parent		Da	ite	-	Γime			
☐ Other (Specify)		(YYYY/MM	/DD)				
Witness Signature Witness Printed N	ame							
* One Witness (health professional) should confirm consent for patients unable to sign and for telephone consent.								
Obtaining Consent of a Non-English Speaking Patient	For		Section I	and/or		Section II		
I acknowledge that I have interpreted the contents of this Consent Form to the patient and I believe that the patient understands the contents.								
Signature of Interpreter		Da	ite	7	Γime			
		(YYYY/MM	/DD)				
Procedure for Emergencies When Patient Unable to Give Conse	nt				For Sec	tion II only		
I/We hereby certify that this is a true emergency, that the patient is unable to give conser	nt, and t	here	is no indicat	ion the p	oatient h	as		
withheld consent for this procedure.								
Signature of Physician # I		Da	ite		Γime			
		(YYYY/MM	/DD)				
Signature of Physician # 2		Da (ite YYYY/MM		Γime			
* Two physician signatures when considered appropriate.								
Procedure for Needed Treatment Under Section 20.1, Dependent Ad	dults A	ct			For Sect	ion II only		
We hereby certify that this patient is in need of treatment and we have been unable to co			l guardian: a					
designate an agent to give the consent and a personal directive does not contain any clea		_	-					
Signature of Physician # I		Da			Γime			
		1	YYYY/MM					
		Da			Γime			
orginated to or injuricular # 2		1	YYYY/MM		illie			
*Two physician signatures required when unable to obtain consent or instruction from a	n porco			100)				
* Responsible Physician should itemize steps taken to obtain consent in a progress note	or on t	his si	neet.					
Notes:								