CONSENT FORM
(H.C.) (L.C.S.C.)

DT9082

1. General consent
2. Consent to surgery
3. Consent to sterilizing surgical intervention
4. Consent to anesthesia
5A, 5B. Consent to specific examinations or treatments
6A, 6B. Refusal to undergo a specific examination or treatment
7. Departure without discharge

N.B.: Make sure that the persons signing this form are authorized to do so under the legislation in force. Where necessary, please indicate in what capacity (curator or holder of parental authority) a person is authorized to sign.

1- GENERAL CONSENT *(to be completed upon admittance)*

Name of the establishment _____

I hereby authorize the physicians, the dentists and attending personal to give me the necessary care and services. I also authorize the establishment and attending or consulting physicians or dentists to give the ministère de la Santé et des Services sociaux the information it requires on this hospitalization, and to give the Régie de l'assurance-maladie du Québec the information it requires to take the steps provided for in section 10 of the Hospital Insurance Act or in section 78 of the Act respecting health services and social services and amending various legislation and section 151 of the Act respecting health services and social services for Cree and Inuit Native persons. The information transmitted to the MSSS and RAMQ is governed by the Act respecting Access to documents held by public bodies and the Protection of personal information, and by the Health Insurance Act.

Date Year Month Day	Signature of user or authorized person	Signature of witness

2- CONSENT TO SURGERY

I hereby authorize Doctor _____ to perform the surgery which includes the operation(s) identified below. _____
Specify type of intervention

I declare that I have been informed of the nature and possible risks or effects of this intervention.
I hereby authorize any other unforeseen operation that may be required at the time of this surgical intervention and for which it would be impossible to obtain my consent.
I also authorize the establishment to dispose of the tissues and organs removed.

Date Year Month Day	Signature of user or authorized person	Signature of witness
Date Year Month Day	* Co-signature of physician or dentist responsible for the intervention	Signature of witness

3- CONSENT TO STERILIZING SURGICAL INTERVENTION

I hereby authorize Doctor _____ to perform the surgery which includes the operation(s) identified below. _____
Specify type of intervention

I declare that I have been informed of the nature and possible risks or effects of this intervention.
I acknowledge that the nature of the proposed intervention and the consequences it entails were fully explained to me by

Doctor _____ and that the intervention is being performed with the intent to render me sterile. However, I have been informed that this intervention does not ensure sterility in every case and no such guarantee has been given to me.
I realize that, if successful, this surgical intervention will result in permanent sterilization, thereby making it impossible for me to conceive a child.
I hereby authorize any other unforeseen operation that may be required at the time of the surgical intervention and for which it would be impossible to obtain my consent.
I also authorize the establishment to dispose of the tissues and organs removed.

Date Year Month Day	Signature of user or authorized person	Signature of witness
Date Year Month Day	* Co-signature of physician or dentist responsible for the intervention	Signature of witness

**** By signing this document, the co-signatory his(her) full awareness of the content of this document.***

4- CONSENT TO ANESTHESIA

At the time of _____ ,

I consent to general anesthesia, or to _____ being administered to me

by Doctor _____ or any other physician who has privileges to practise anesthesiology in this establishment.
I declare that I have been fully informed of the nature and possible risks or effects of this anesthesia.

Date Year Month Day	Signature of user or authorized person	Signature of witness
Date Year Month Day	* Co-signature of physician or dentist responsible for the intervention	Signature of witness

5A- CONSENT TO SPECIFIC EXAMINATIONS OR TREATMENTS

I hereby authorize Doctor _____ to perform the following examination or administer the

following treatment: _____
Description of the examination or treatment

The number of authorized electroshock treatments, should they be necessary, is from _____ to _____ .
I declare that the attending physician or dentist has fully explained to me the nature and the possible risks or effects of this examination or treatment.

Date Year Month Day	Signature of user or authorized person	Signature of witness

6A- REFUSAL TO UNDERGO A SPECIFIC EXAMINATION OR TREATMENT

I hereby refuse to undergo the following examination or treatment: _____

_____
Description of the examination or treatment

The examination or treatment was recommanded to me by: _____
Name of the physician or dentist responsible

I declare that I have been informed of the risks and consequences that may result from my refusal to undergo the recommended examination or treatment.

Date Year Month Day	Signature of user or authorized person	Signature of witness

5B- CONSENT TO SPECIFIC EXAMINATIONS OR TREATMENTS

I hereby authorize Doctor _____ to perform the following examination or administer the

following treatment: _____
Description of the examination or treatment

The number of authorized electroshock treatments, should they be necessary, is from _____ to _____ .
I declare that the attending physician or dentist has fully explained to me the nature and the possible risks or effects of this examination or treatment.

Date Year Month Day	Signature of user or authorized person	Signature of witness

6B- REFUSAL TO UNDERGO A SPECIFIC EXAMINATION OR TREATMENT

I hereby refuse to undergo the following examination or treatment: _____

_____
Description of the examination or treatment

The examination or treatment was recommanded to me by: _____
Name of the physician or dentist responsible

I declare that I have been informed of the risks and consequences that may result from my refusal to undergo the recommended examination or treatment.

Date Year Month Day	Signature of user or authorized person	Signature of witness

7- DEPARTURE WITHOUT DISCHARGE

I declare that I am leaving this establishment on my own initiative, at my request, and against the advice of the attending physicians or dentists; I therefore release the establishment, its staff and the attending physicians or dentists of all responsibility for the consequences of this departure.

Date Year Month Day	Signature of user or authorized person	Signature of witness

**** By signing this document, the co-signatory his(her) full awareness of the content of this document.***