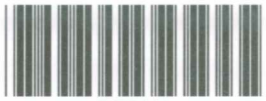
CONSENT FORM
HOSPITAL CENTRE FOR LONG-TERM CARE (HCLTC)



DT9111

1. General consent
2. Consentement to specific examinations or treatments
3. Refusal to undergo a specific examination or treatment
4. Departure without discharge

This form is valid for all RESIDENTIAL AND LONG-TERM CARE CENTRES.

File No.: Date of admission:

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) a person is authorized to sign.

1- GENERAL CONSENT

Name of the establishment _____

I hereby authorize the physicians, dentists, contract staff and employees of the establishment to give me care and services under the program.

_____
(permanent or temporary residential and long-term care centre, pavilion, foster home, day centre, day hospital, intensive, functional rehabilitation service, etc.)

for an duration of _____
(undetermined, anticipated number of days, weeks or months)

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 admission or registration, and to give the Régie de l'assurance-maladie du Québec the information it requires to take the steps provided for 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 the 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: user or authorized person	Signature of witness

2- 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

I acknowledge that the attending physician or dentist has fully explained to me the nature and the risks or possible effects of this examination or treatment.

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

3- 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 recommended 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: user or authorized person	Signature of witness

4- 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 for what may result from this departure.

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