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Form M-1C
Rev. 4-2005

Vancouver Coastal Health Authority

Consent:

1. Health Care: Medical or Surgical
2. Administration of Blood Products

1. Health Care: Medical or Surgical

On behalf of the patient named above, I (the patient or his or her substitute decision maker) agree to the following treatment or procedure _____

_____

(describe treatment/procedure) under the direction of _____ (doctor's name),

M.D./D.D.S./Other _____ type of doctor)

The nature, anticipated effects, available alternatives and significant risks of the treatment, surgical operation, or procedure described above have been explained to me, and I understand the explanation.

I also agree to receive anesthesia and such anesthetics as may be considered necessary. I understand and agree that for the purpose of medical education and improvement of services: 1) there may be residents/students attending my treatment/procedure, either watching or participating, 2) that tissues, bodily fluids, devices, or implants removed in this procedure become the property of the hospital and may be used for such purposes, including teaching or research, as is approved by the hospital, 3) for quality improvement and other follow up, information about follow-up care in my doctor or dentist's office may be given to the hospital by my doctor or dentist, and 4) if receiving an implant, personal information such as my name and address must be sent to the provider of that implant, and will be subject to the laws of the country in which the implant originated.

I further agree that, if he or she finds it necessary, the health care provider named above may have other surgeons, physicians and hospital staff assist him or her and may permit them to order and/or perform all or part of my treatments, surgical operation, or procedure. I also agree that these other health care providers may have the same discretion in my treatment, operation, or procedure as the provider named above.

I also consent to such additional or alternative treatments, surgical operations, or procedures as the health care provider named above finds immediately necessary.

Signed: _____ _____/_____Hrs
(Patient, or person legally authorized to give consent) (Date & Time of Patient Signature)

_____ Signature of M.D./D.D.S.: _____
(Relationship to patient if not the patient) (Provider obtaining consent)

Print Name: _____
(If not patient)

Witness: _____ Print Name: _____
(When MD not present at time of signing) (Witness)

2. Administration of Blood Products

1. My doctor _____ (doctor/surgeon's name) has told me that during the treatment, _____ it may be necessary for me to receive **administration (transfusion, infusion, or injection)** of **blood products (blood, blood components or other blood products)** such as red blood cells, plasma, cryoprecipitate, factor concentrate, platelets, albumin or immunoglobulins (IM or IV).

2. My doctor has told me about the risks of receiving blood products from volunteer donors. I understand that risks exist even though the blood products have been tested. I understand that in most cases the risks are small; however, serious injury and/or death may result in some cases.

3. My doctor has discussed autologous blood donation and other suitable alternatives with me. I have been told that even if my own blood is used, it may still be necessary for me to receive other blood products.

4. I have been given information on administration of blood products and the chance to ask questions about the benefits and risks of blood products. My doctor has answered my questions to my satisfaction.

I consent to the administration of blood products if it becomes necessary during my treatment.

Signed: _____ _____/_____Hrs
(Patient, or person legally authorized to give consent) (Date & Time of Patient Signature)

_____ Signature of M.D./D.D.S.: _____
(Relationship to patient if not the patient) (Provider obtaining consent)

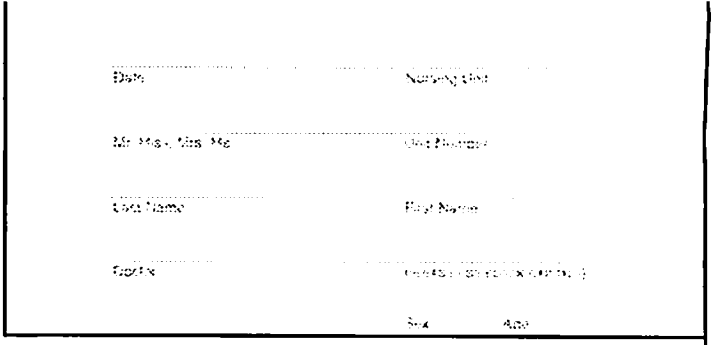
Print Name: _____
(If not patient)

Witness: _____ Print Name: _____
(When MD not present at time of signing) (Witness)

Vancouver Coastal Health Authority

Consent: Special Considerations

1. Health Care: Medical or Surgical
2. Administration of Blood Products



Declaration by Interpreter:

I have accurately translated interpreted this document and acted as interpreter for the patient, who told me that he/she understood the explanation and consents to the treatment described on the other side of this form.

_____ _____
Time Date

Signature of Interpreter _____

Print Name: _____
(Interpreter)

Telephone Consent: Health Care, and/or Blood Products

I have discussed the procedure outlined on the other side of this form and the anticipated effects of such treatment, surgical operation, or special procedure, including the significant risks and alternatives outlined with _____ who is the patient's (state relationship) _____, and he/she has given verbal consent for the procedure named above.

_____ _____
Time Date

Signature of M.D./D.D.S.: _____

Print Name: _____
(Provider)

Certificate of Need for Urgent/Emergency Health Care

Medical Opinion(s) Regarding the Need for Urgent/Emergency Health Care — Including Blood Products

I hereby certify that it is necessary to provide the following health care: _____, without delay in order to save the adult's life, to prevent serious physical or mental harm, or to alleviate severe pain, and the adult is, in my opinion, incapable of giving or refusing consent, and has not previously indicated (in the case of blood products, to preserve life or health) that consent would be refused.

I have been unable to consult with any available substitute decision-maker, within a reasonable time in the circumstances .

_____ _____
Time Date

Signature of M.D./D.D.S.: _____

Print Name: _____
(Provider)

It is recommended, but not mandatory, that a second medical staff member of the Vancouver Coastal Health Authority — not a resident — sign this form.

I agree with the need for the health care set out above for this patient and with the opinion on incapability. This patient's condition poses an immediate threat to his/her life or health and emergency or urgent treatment is required.

_____ _____
Time Date

Signature of M.D./D.D.S.: _____

Print Name: _____
(Provider)

Comments