SHN
SCARBOROUGH HEALTH NETWORK

STATEMENT OF INFORMED CONSENT

TREATMENT / TEST / OPERATION:

_____

_____

_____

(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, risk, 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.

Signature of Patient/Substitute Decision Maker (SDM)	Print Name	Date
Signature of Translator (if required)	Print Translator's Name	If signed by SDM, state relationship to patient

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 blood including blood products manufactured from donor blood have been discussed with me and all questions have answered to my satisfaction.

Signature of Patient/Substitute Decision Maker (SDM)	Print Name	Date
Signature of Translator (if required)	Print Translator's Name	If signed by SDM, state relationship to patient

PHYSICIAN / DENTIST / MIDWIFE OR ALLIED PROFRESSIONAL PERFORMING DELEGATED MEDICAL ACTS STATEMENT:
I have explained the anticipated nature, material risk and side effects, any alternative course of action, likely consequences of not having the above treatment / test / operation, that other qualified individuals may assist in the treatment and have responded to the questions or concerns of the patient / SDM.

Signature of Practitioner	Name of Practitioner (Print Name)	Date
Signature of Witnessing Practitioner (If telephone/virtual consent)	Name Witnessing of Practitioner (Print Name)	Date

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STATEMENT OF INFORMED CONSENT

841270

TREATMENT IN EMERGENCY WITHOUT CONSENT

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

Signature of Practitioner	Name of Practitioner (Print Name)	Date

FOREIGN RESIDENTS AGREEMENT

Governing Law and Jurisdiction Agreement for Health Care Organizations

This agreement is entered into by and between _____ (name of patient) and Scarborough Health Network (collectively, the "parties")

Governing Law

The Parties here by 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 or in association with Scarborough Health Network, including without limitation any medical, or other healthcare and treatment provided to me, and
b) The resolution of any and all disputes arising from or in connection with that relationship, including any dispute 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 (other than conflict of laws rules) and the laws of Canada applicable therein.

Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment I receive from the Scarborough 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 complaints, demand, claim, proceeding, or cause of action, whatsoever, arising from or in connection with that medical or other healthcare and treatment, or from any other aspect my relationship to the Scarborough Health Network.

Signature of Patient/Substitute Decision Maker (SDM)	Print Name	Date
Signature of Translator (if required)	**Print Translator's Name**	**If signed by SDM, state relationship to patient**
Signature of Practitioner	**Name of Practitioner (Print Name)**	**Date**

Distribution: Patient Chart