

Name <i>(last first)</i>	
Birthdate <i>(yyyy-MM-dd)</i>	Gender <input type="checkbox"/> M <input type="checkbox"/> F
PHN/ULI	

Consent to Treatment Plan or Procedure
(Policy PRR-01)

Telephone Fax Consent			
Consent was given via <input type="checkbox"/> Telephone <input type="checkbox"/> Fax/Scan			
Name of Most Responsible Health Practitioner	Signature	Date <i>(yyyy-Mon-dd)</i>	Time
Witness Name <i>(to telephone call)</i>	Signature	Date <i>(yyyy-Mon-dd)</i>	Time

Interpreter			
Obtaining Consent from a Non-English Speaking Patient			
I acknowledge that I have interpreted the information given to me about the treatment plan or procedure and the content of this consent form to the person giving consent and I believe to the best of my ability that the person understands the information.			
Interpreter name <i>(print)</i>	Signature or "by telephone"	Date <i>(yyyy-Mon-dd)</i>	Time

Withdrawal of Consent			
<input type="checkbox"/> I withdraw my consent for the entire treatment plan or procedure as detailed on Side A. I am aware of the risks and consequences of this withdrawal. <input type="checkbox"/> I withdraw my consent for the following specific portions of the treatment plan or procedure. I am aware of the risks and consequences of this withdrawal.			
Name of person withdrawing consent	Signature	Date <i>(yyyy-Mon-dd)</i>	Time
Note: Health practitioner who has documented the withdrawal of consent should inform the Most Responsible Health Practitioner of the withdrawal of consent to the treatment plan or procedure.			

Definitions
<p>Legal Representative: acting on behalf of a Minor Patient under the age of 18 years who is not determined to be a Mature Minor (<i>Guardian; divorced parent with custody; person appointed by Guardian to act on behalf of Guardian where Guardian is temporarily absent; any other person authorized by law to consent</i>).</p> <p>Agent: an adult appointed in an enacted personal directive in accordance with the <i>Personal Directives Act</i>.</p> <p>Guardian: an adult appointed in a Guardianship Order to act on behalf of an adult patient.</p> <p>Specific Decision Maker: an adult relative selected to act on behalf of a patient when a patient lacks capacity and an Alternate Decision Maker is not already identified (<i>Guardian or Agent</i>). There is a specific process and form (<i>AGTA Form 6</i>) to follow for selecting a Specific Decision Maker in accordance with the <i>Alberta Guardianship and Trusteeship Act</i>.</p> <p>Co-Decision Maker: appointed by court order to assist an adult whose ability to make decisions is severely impaired, but who can still make decisions with good support. The Adult and Co-Decision Maker are required to make decisions together and both sign the appropriate consent form when written (<i>signed</i>) consent is required or the Most Responsible Health Practitioner has determined the need for written (<i>signed</i>) consent.</p>

Name (last, first)	
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Instructions: If the person providing consent disagrees to an item on this consent form, **strikeout** the text and have them initial beside it.

Patient Name

Details of Treatment Plan or Procedure *(write in full without abbreviations)*

I confirm that the nature, benefits, risks, consequences, and alternatives of the treatment plan or procedure *(as detailed above)* and related matters have been explained to me. I am satisfied with and understand the information I have been given, and I consent to the treatment plan or procedure.

_____ *(name/service)* will perform this treatment plan or procedure with the assistance of any other healthcare practitioners including medical students, residents and others in training.

I understand that I may, at any time, withdraw consent to this treatment plan or procedure *(as detailed above)* or any other related matter.

Name of person(s) providing consent	Specify role of person(s) providing consent <input type="checkbox"/> Patient (adult) <input type="checkbox"/> Parent (with legal authority to consent) <input type="checkbox"/> Patient (mature minor) <input type="checkbox"/> Co-decision Maker <input type="checkbox"/> Agent <input type="checkbox"/> Guardian/Legal Representative <input type="checkbox"/> Specific Decision Maker <i>(relationship to Patient)</i> _____
Phone #	

Signature of person providing consent	Date (yyyy-Mon-dd)	Time
Signature of Co-decision Maker <i>(if applicable)</i>	Date (yyyy-Mon-dd)	Time

Note: When an individual other than the patient provides consent, a copy of the court order, personal directive, or other document authorizing them to do so must be kept on the health record.

Witness Statement

I observed the person providing consent sign the consent form *(Witness must be at least 18 years of age)*

Witness name <i>(print)</i>	Signature	Date (yyyy-Mon-dd)	Time
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Most Responsible Health Practitioner Statement

I have explained the treatment plan or procedure to the person providing consent. In my opinion, this person understands the nature, benefits, risk, consequences, and alternatives.

Name	Signature	Date (yyyy-Mon-dd)
If the person obtaining consent has been delegated to do so by the Most Responsible Health Practitioner, specify role <input type="checkbox"/> Physician <input type="checkbox"/> Resident		Time