CONSENT FORM

Santé et Services sociaux Québec

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 or inscription)*

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 pharmacists who practice their profession in community pharmacies with access to my medication profile to provide the health care institution with the content of my profile as well as any other information deemed relevant that will enable the treating team of the institution to provide me with optimal health care. 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.***

User's name	File no.

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

5- 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

6- CONSENT TO BLOOD SAMPLING FOLLOWING ACCIDENTAL EXPOSURE

If, during any intervention, examination, treatment, procedure, surgery or other, a doctor, a nurse or any other healthcare professional accidentally comes into contact with my blood or other bodily fluid and my consent cannot be obtained in due time,

I hereby authorise a blood sample be taken off my person for the purpose of screening for the human immunodeficiency virus (HIV), the hepatitis B virus (HBV) or the hepatitis C virus (HCV). If the situation arises, the healthcare institution will notify me, or my representative, as soon as possible.

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

7- 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

8- 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

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