



CONSENT FORM

Établissement :		
1. General consent	5A, 5B.	Consent to specific examinations or treatments
2. Consent to surgery	6A, 6B.	Refusal to undergo a specific examination or treatment
3. Consent to sterilizing surgical intervention	7.	Departure without discharge
4. Consent to anesthesia		
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 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
<i>*By signing this document, the co-signatory his(her) full awareness of the content of this document.</i>		

