Here is a general **Consent for Treatment Form** that can be adapted for use at hospitals, clinics, or health institutions such as **London Health Sciences Centre (LHSC)** or similar facilities. It covers standard legal and ethical requirements.

Consent for Treatment Form

London Health Sciences Centre (LHSC)
CONFIDENTIAL

Patient Name: _____
Date of Birth (DD/MM/YYYY): _____
Health Card Number (OHIP): _____

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1. Purpose of this Form

This form is intended to document your informed consent to receive medical treatment, including diagnostic procedures, therapeutic interventions, and surgical or medical care provided by healthcare professionals at LHSC.

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2. Description of Treatment

I authorize the physicians, nurses, and healthcare providers involved in my care to carry out the recommended treatment(s), which may include:

- Physical examinations
- Diagnostic tests (e.g., lab work, imaging)
- Administration of medications or intravenous fluids
- Minor procedures and/or surgical interventions
- Anesthesia or sedation, if required
- Other treatments necessary for my health and well-being

I understand that additional procedures may be required based on findings during the course of treatment.

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3. Risks, Benefits, and Alternatives

I understand that:

- My healthcare provider has explained the **nature and purpose** of the recommended treatment.
- I have been informed of the **potential risks**, **benefits**, and **alternatives**, including the option of refusing treatment.
- I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

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4. Right to Refuse or Withdraw Consent

I understand that:

- I may refuse treatment at any time.
- I may withdraw this consent at any time, except when treatment is already in progress and cannot be safely stopped.
- My decision to refuse or withdraw treatment will not affect the quality of care I receive.

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5. Privacy and Confidentiality

I understand that:

- My health information will be collected, used, and disclosed in accordance with the **Personal Health Information Protection Act (PHIPA)**.
- My information will be shared only with those involved in my care, or as permitted or required by law.
- I may request access to my health records at any time.

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6. Consent for Photography or Recording

☐ I give consent for **photographs/videos/audio recordings** to be taken for diagnostic, treatment, or education purposes.
☐ I do **not** give consent for photographs/videos/audio recordings.

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7. Interpreter Services

☐ An interpreter was used to assist in explaining this form.
Language: _____
Interpreter Name: _____

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8. Patient Consent

I hereby consent to receive medical treatment as described above.
I confirm that I have read and understood this form, or it has been read to me, and that all my questions have been answered.

Patient Signature: _____
Date: _____

If the patient is unable to consent, the substitute decision-maker (SDM) must sign below.

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9. Substitute Decision-Maker (SDM)

Relationship to patient: _____
Legal authority: ☐ Power of Attorney ☐ Legal Guardian ☐ Other: _____

SDM Name (print): _____
SDM Signature: _____
Date: _____

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10. Witness

Witness Name (print): _____
Witness Signature: _____
Date: _____

📞 If you have questions about your care or this form, please contact your care team or visit:
🌐 https://www.lhsc.on.ca

Let me know if you'd like a version specific to **surgery, mental health treatment, diagnostic testing**, or in **another language**. I can also format this into a PDF or digital consent form.