Name:

DOB:

HC#:

PETERBOROUGH REGIONAL HEALTH CENTRE
CONSENT TO TREATMENT

I, ______________________________________, consent to the planned treatment described below,
(Printed Name of Patient/Substitute Decision Maker)
including all related tests & treatments and the giving of a general and/or other anaesthetics as may become medically necessary during the course of the treatment being performed on

____
(Printed Name of Patient)

____
(Proposed Treatment)

The nature, material side effects, material risks, possible alternative action, and the consequences of not having the treatment have been explained to me by:

Dr. L. K. Ebisuzaki or his/her designate. ______________________________________.
(Name of Health Practitioner) ***(Name of Health Practitioner Designate)***

I understand and I am satisfied with the explanation about the material side effects, material risks and the expected benefits, of the treatment that will be performed on me. I have been given time to ask questions and my questions have been answered to my satisfaction.

I understand that other health care practitioners may be involved in these procedures – either in an educational or therapeutic role. I agree that my physician (or other health care practitioner) may call upon the assistance of other surgeons, physicians and/or hospital staff as appropriate and may allow them to order or perform all or part of the treatment as required.

I authorize the hospital and its staff to utilize any tissue specimens removed during the procedure for further necessary clinical investigations, quality assurance, teaching purposes or research that has been approved by the Research Ethics Board. I acknowledge that the hospital will dispose of the same according to approved hospital practice.

I declare that I have read the above Consent to Treatment, or it has been read and explained to me and I fully understand the same.

______________________	______________________	______________________
(Signature of Patient/or Substitute Decision Maker)	***(Relationship to patient)***	***Date (dd/mm/yyyy)***

TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE TREATMENT

(Failure to complete this portion of the consent form may result in the withholding of treatment to this patient)

I confirm that I have either (a) personally explained or (b) arranged for ____________________ to explain, the anticipated effects, the nature, alternate courses of action, the material risks, and special or unusual risks of what is proposed for this patient and afforded the person who has signed this form an opportunity to ask questions which I have answered. In my opinion, he/she is capable of understanding and appreciating the information that has been given.

______________________	______________________	______________________
(Printed name of Health Practitioner)	***(Signature of Health Practitioner)***	***Date (dd/mm/yyyy)***

Peterborough Regional Health Centre
Surgery & Outpatient Procedures
1 Hospital Drive, Peterborough, ON K9J 7C6
(705) 743-2121 web: www.prhc.on.ca

Patient Name:
DOB:

Patient Name:
Date of Birth (dd/mm/yy)
Scheduled Procedure Date & Time
Surgeon / Attending Physician
Family Doctor
Diagnosis
Procedure

PATIENT ADMISSION QUESTIONNAIRE (PAQ)

This form has 3 pages and is to be completed by Patient, Guardian or Substitute Decision Maker (SDM), and brought with you when you come to the hospital.

Please make sure your name is on all pages.

Page 1 of 3

Please check yes or no if you have, or ever had, any of the following:

Specialists			notes requested
Have you ever seen a Dr. for your **heart** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a Dr for your l**ungs** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a Dr for your **kidneys** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a **Neurologist** ☐ No If yes, name of Dr.	Where:	When:	☐

Have you ever seen any specialists that you have not already listed? Yes ☐ **No** ☐

Have you been treated or hospitalized for any major illness or had surgery in the past? Yes ☐ **No** ☐

If yes, when, where, what type?

Release of Patient Information

I ______________________________ give consent for PRHC to retrieve my medical records from my Family Doctor / Specialist or medical facility as required for my care at PRHC.

______________________________ Signature

______________________________ Date

This Area for Patient to check	**Yes**	**No**	SOP Nursing Assessment
Do you have an Advance Medical Directive? ie. Do Not Resuscitate (DNR) Status	☐	☐	
Have you or a family member had a problem with a previous local or general anesthetic?	☐	☐	
History of malignant hyperthermia (or a relative?)	☐	☐	
ENDOCRINE			SOP Nursing Assessment
Diabetes: ☐ Diet ☐ Pills ☐ Insulin ☐ Insulin pump	☐	☐	
Thyroid disease	☐	☐	
Could you be pregnant?	☐	☐	

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Patient Name:
DOB:

CARDIOVASCULAR	Yes	No	SOP Nursing Assessment
Do you have to stop to catch your breath when climbing 2 flights of stairs	☐	☐	
Angina, chest tightness or pain	☐	☐	
Heart attack (MI)	☐	☐	
Hypertension (high blood pressure) or take medication for this	☐	☐	
Heart failure	☐	☐	
Swelling of your ankles	☐	☐	
Pacemaker / ICD	☐	☐	
Irregular Pulse / Palpitations	☐	☐	
Heart Murmur	☐	☐	
Heart Surgery	☐	☐	
Stent	☐	☐	
Dizziness, Blackouts	☐	☐	
RESPIRATORY			
Do you smoke? If yes, how many per day for how many years	☐	☐	
Do you want to quit smoking?	☐	☐	
Have you ever smoked? When did you quit	☐	☐	
Difficulty breathing at night	☐	☐	
Asthma / cough / wheeze	☐	☐	
Tuberculosis	☐	☐	
Bronchitis	☐	☐	
Emphysema	☐	☐	
Shortness of breath	☐	☐	
COPD	☐	☐	
Sleep Apnea: ☐ Oral appliance ☐ IPAP ☐ CPAP	☐	☐	
Have you had a cold recently	☐	☐	
GASTROINTESTINAL			
Heartburn / Hiatus Hernia (reflux)	☐	☐	
Difficulty swallowing	☐	☐	
Easily nauseated	☐	☐	
Jaundice / Liver disease	☐	☐	
Hepatitis if yes, type?	☐	☐	
GENITOURINARY			
Kidney problems	☐	☐	
Are you on Dialysis?	☐	☐	
NEUROLOGIC			
Stroke / TIA's	☐	☐	
Head injury	☐	☐	
Seizures or convulsions	☐	☐	
Confusion / Dementia	☐	☐	
Spinal Cord Problems	☐	☐	
Numbness or tingling arms or legs	☐	☐	
Muscle weakness	☐	☐	

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DOB:

OTHER	Yes	No	
HIV / AIDS	☐	☐	
Arthritis ☐ Osteoarthritis ☐ Rheumatoid	☐	☐	
Cancer Where?	☐	☐	
Anemia	☐	☐	
Bleeding disorder	☐	☐	
Do you drink alcohol /beer / wine?	☐	☐	
Have you had a blood transfusion?	☐	☐	
Emotional distress / anxiety	☐	☐	
TEETH			
Loose teeth	☐	☐	
Chipped teeth	☐	☐	
Dentures ☐ upper ☐ lower	☐	☐	
Permanent Bridge	☐	☐	
Bonded or capped teeth	☐	☐	
HEARING			
Hearing loss	☐	☐	
Hearing aids	☐	☐	

Current Medications

Name of Medication	Name of medication

Do you have any medication allergies?

Name of medication	Reaction Example: Rash or hives or swelling etc	Comments (nursing)

Do you have any other allergies?

(e.g. Latex- rubber gloves, Food- nuts, bananas, shellfish, chestnuts Environmental – pollen, pets, grass)

Allergy	Reaction Example: Rash or hives or swelling etc	Comments (nursing)

Nurse's Signature	Initials	Date

PRHC
Peterborough Regional Health Centre

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Patient's Name	**PRE-OPERATIVE DIAGNOSTIC TESTING - Physician's Order Sheet**		
Date of Birth (dd/mm/yy)			
Scheduled Procedure Date & Time MM/DD/YYYY		Adult	Child
Surgeon / Attending Physician	Same Day Admit	☐	☐
Family Doctor	Inpatient	☐	☐
Diagnosis	Surgical Outpatient	☐	☐
Procedure	Medical Outpatient	☐	☐

Laboratory Medicine

	Test	Indication
☐	CBCD	- < 1 month old (or 50 weeks gestational age) - Major Surgery: such as total hip/knee, vascular, bowel resection, hysterectomy, prostatectomy/ cystectomy/ nephrectomy
☐	ECG	- Major surgery as defined above **WITH** a history of: coronary artery disease (CAD)/ angina; cerebral vascular accident (CVA)/Transient Ischemic Attack (TIA); peripheral vascular disease (PVD); heart failure; renal failure/ dialysis - any history of myocardial infarction - Known arrhythmia (other than atrial fibrillation or flutter) - Diabetes
☐	Urea (BUN), creatinine, electrolytes (K, Na, Cl)	- Major surgery as defined above, - On diuretics, angiotensin-converting-enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARB) - Diabetes, - Renal failure - if on dialysis, test to be done **ONLY** on day of surgery
☐	INR	- All patients on warfarin - note this is **ONLY** to be done on the day of surgery - Cirrhosis of the liver
☐	SIC (Sickle Test)	High risk groups - (West Central Africa, Saudi Arabia, East Central India, Southern Italy, Northern Greece, Southern Turkey, African American, Caribbean)
☐	Transfusion Medicine Type & Screen	Maximum Surgical Blood Order Schedule (MSBOS) as standardized for above procedure. **This must be done at same hospital as the procedure. Pregnant patients must have this done within 4 days of surgery date. New type and screen needed if original T & S is greater than 6 weeks**

Diabetic patients – a blood glucose in SOP on day of surgery.

A pregnancy test may be required on day of surgery if a patient is unsure she is pregnant.

Diagnostic Imaging

(Clinical reason for exam)

Other tests: (Specify) ______________________

Ordering Physician Signature: ______________________ Date (d/m/y): ________________

Please send results to:

☐ Surgeon's office

☐ Family Doctor

☐ PRHC Fax @ (705) 876-5103

*****Note*****

Pre-op blood work must be done prior to day of surgery, up to 8 weeks before date of booked surgery. If Transfusion Medicine blood work is needed, all testing can be done at PRHC.