I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[name of patient or the substitute decision-maker (SDM) listed below]

consent to have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[name of practitioner]

perform the following treatment\* on me:

Describe specific treatment or specific plan of treatment. For example, acupuncture and herbal prescription for 8 weeks, with at-home exercises. [Note that the practitioner should not obtain a “blanket consent” to cover every procedure when the patient first comes in.]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If treatment includes sensitive areas, I, consent to have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,

[name of practitioner]

provide assessment and/or treatment of the areas indicated below:
[please check the appropriate box(es)]

🞎 Upper and inner thigh 🞎 Vagina

🞎 Buttocks 🞎 Breasts

🞎 Penis 🞎 Chest wall muscles

I acknowledge that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[name of practitioner]

has explained the following to me:

* the nature of the treatment, as set out above
* if applicable, the clinical reason(s) for the assessment of the above sensitive area(s) and the draping methods to be used the expected benefits of the treatment
* the material risks of the treatment
* the material side effects of the treatment
* the alternatives to having the treatment
* the likely consequences of not having the treatment

I acknowledge that my practitioner cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my practitioner about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that my consent is voluntary, and I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my practitioner has explained the applicable fees to me.

**I acknowledge that I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand.**

|  |
| --- |
| By signing this form, I give my informed consent for the treatment set out above. |
| **Signature of Patient/SDM:** |  | **Date** |  |
| **Signature of Patient/SDM:** |  | **Date** |  |
| **Signature of Patient/SDM:** |  | **Date** |  |
| **Signature of Patient/SDM:** |  | **Date** |  |
| **Signature of Patient/SDM:** |  | **Date** |  |
| By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient’s (or substitute decision-maker’s) questions. |
| **Practitioner’s Signature:** |  | **Date:** |  |
| **Practitioner’s Signature:** |  | **Date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Practitioner’s Signature:** |  | **Date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Practitioner’s Signature:** |  | **Date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Practitioner’s Signature:** |  | **Date:** |  |