



**CONSENT TO TREATMENT**

I \_\_\_\_\_ D.O.B. \_\_\_\_\_ Hereby consent to undergo the treatment/procedure/operation of \_\_\_\_\_ by Dr.M.Kara on myself.

1. The nature of the treatment/procedure/operation, the expected benefits, the material risks, the material side effects and the alternative courses of action include the likely consequences of not having the treatment/procedure/operation have been explained to me.
2. I further agree that Dr.M.Kara may be assisted by other surgeons, physicians, and hospital medical staff and may permit them to order or perform all or part of the investigation/treatment or operative procedure, and I agree that they shall have the same discretion in my investigation and treatment.
3. I also consent to such addition or alternative procedures as may be necessary or medically advised during the course of such procedure.
4. In addition, I consent to the administration of such anesthetic as are necessary or medically advised during the course of such procedures.
5. In compliance with provincial legislation, I acknowledge that Dr.M.Kara may utilize any organs or tissue specimens removed during procedure(s) for the research and or teaching purposes.
6. This facility is a member of the Canadian Association for Accreditation of Ambulatory Surgery Facilities and as part of the requirements your chart may be subject to a peer review for quality control by the Canadian Society for Accreditation of Ambulatory Surgery Facilities
7. The consent is modified as follows: \_\_\_\_\_  
\_\_\_\_\_

I understand the explanation and am satisfied that my questions have been answered.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Doctor)

\_\_\_\_\_  
(Date)