HOTEL DIEU HOSPITAL

KGH KINGSTON GENERAL HOSPITAL

CONSENT FOR
SPECIAL RADIOLOGICAL PROCEDURE(S)

Completion of this form is required for the radiological procedures designated as requiring written consent.

Part A is the responsibility of the physician ordering the procedure, and **Part B** is the responsibility of the radiologist who will perform the procedure.

Part A

1. I, _____, hereby consent to undergo the radiological procedure,_____
_____
_____.

2. The reasons for the procedure, its potential benefits, possible alternatives, and risks have been explained to me by _____, and I confirm that I understand the explanation.
(HEALTH PRACTITIONER)

3. I understand that a radiologist will discuss with me the anticipated nature, effect, material risks and special or unusual risks of what is proposed.

Dated _____
YYYY / MM / DD

_____
Signature of Patient or Substitute Decider (If other than patient, designate relationship.)

_____
Signature of Physician

4. **FOREIGN RESIDENTS ONLY:** I agree that the relationship between myself and _____
(Physician)
and between myself and the hospital shall be governed in accordance with the laws of the Province of Ontario. I acknowledge that investigation(s), treatment(s), or operative procedure(s) will be performed in the Province of Ontario and that the Courts of the Province of Ontario will hear any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of any investigation, treatment or operative procedure(s). In the event that I decide to commence any legal proceedings against the Medical Staff and/or Hotel Dieu Hospital and/or Kingston General Hospital, I will bring such action in the Province of Ontario and only in the Province of Ontario.

Dated _____
YYYY / MM / DD

_____ _____
SIGNATURE OF PATIENT OR SUBSTITUTE DECIDER (IF OTHER THAN PATIENT, DESIGNATE RELATIONSHIP.) SIGNATURE OF PHYSICIAN

5. This consent has been obtained by telephone: ☐

HOTEL DIEU HOSPITAL

KINGSTON GENERAL HOSPITAL

CONSENT FOR
SPECIAL RADIOLOGICAL PROCEDURE(S)

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Part B

1. I, _____, hereby consent to undergo the
(Name of Patient)
radiological procedure, _____

_____

to be performed by _____.
(Radiologist)

2. The nature, effects, risks of what is proposed have been explained to me by
_____ , and I confirm that I understand the explanation.
(Radiologist)

3. I also consent to such additional or alternative treatment or investigative procedures as, in the opinion of _____, are deemed immediately necessary
(Radiologist)
during the course of the aforementioned treatment or investigative procedure (s) and to the administration of general or other anaesthetic as is necessary.

4. I understand that Kingston General Hospital is a teaching hospital and that various health care personnel may assist in my care. I agree that in his or her discretion the radiologist named in (1) may make use of the assistance of other physicians, surgeons, and hospital medical staff and may permit them to order or perform all or part of the treatment or investigative procedure. I also understand that the hospital cannot guarantee the gender, race or religious background of the staff or students who may participate in my care.

Dated _____ _____
YYYY / MM / DD Signature of Patient or Substitute Decider (If other than patient, designate relationship.)

_____
Signature of Physician

5. **FOREIGN RESIDENTS ONLY:** I agree that the relationship between myself and _____
(Physician)
and between myself and the hospital shall be governed in accordance with the laws of the Province of Ontario. I acknowledge that investigation(s), treatment(s), or operative procedure(s) will be performed in the Province of Ontario and that the Courts of the Province of Ontario will hear any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of any investigation, treatment or operative procedure(s). In the event that I decide to commence any legal proceedings against the Medical Staff and/or Hotel Dieu Hospital and/or Kingston General Hospital, I will bring such action in the Province of Ontario and only in the Province of Ontario.

Dated _____
YYYY / MM / DD

_____ _____
SIGNATURE OF PATIENT OR SUBSTITUTE DECIDER (IF OTHER THAN PATIENT, DESIGNATE RELATIONSHIP.) SIGNATURE OF PHYSICIAN

6. This consent has been obtained by telephone: ☐