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,_____________________________________________________________________________________.

Dated ________________

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 ________________

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

Signature of Physician

5. This consent has been obtained by telephone: □
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 B

1. I, ________________________________, hereby consent to undergo the 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 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 _____________________________

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 _____________________________

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

Signature of Physician

6. This consent has been obtained by telephone: ☐

Sap # 187/2003/12