

Dr. Steve Fremeth
102-1500 Bank St
Ottawa, ON K1H 7Z2

Tel: 613-739-1616
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CONSENT TO TREATMENT

Date: _____

Medical Professional: _____

TREATMENT PLAN: Explanation by Medical Professional of:

A. Diagnosis:

B. Plan of Treatment Recommended:

C. Alternate Treatment(s) Identified:

D. Material Risks and Benefits of Treatment/Alternate Treatment and/or Refusal:

CAPACITY TO CONSENT

A. Patient: Capable (Demonstrates personal comprehension of medical condition, nature of proposed treatment and consequences)

Incapable due to:

age

disability impairing comprehension (not solely conclusive)

unable to rationally appreciate consequences of refusing treatment

other: _____

B. Substitute Decision Maker (if patient incapable):

Name: _____

Relationship to Patient: _____

Capable

Incapable (same assessment as A above)

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CONSENT TO TREATMENT

I hereby authorize Dr. _____ (“the doctor”) and such other medical practitioners and other assistants as he/she may select or approve, to implement, perform, or assist in performing on _____ at the Ottawa Surgicentre the following treatment:

Possibility of radiographs, cleaning, fluoride, restorations, endodontic, stainless steel crowns, extractions.

The doctor has given me an explanation of, and I understand, the nature of this treatment, operation or procedure, the risk involved, its probable effects and possible benefits.

I authorized the doctor to take whatever methods he/she considers necessary or desirable in addition to, or different from the treatment, operation or procedure initially contemplated in the event that any condition is discovered in the course of the treatment, operation or procedure that was not previously apparent and my consent cannot reasonably be sought.

I understand that I may withdraw consent at any time, although a started procedure may need to be completed in order to protect my life/save me from serious harm.

Date: _____
_____ (Signature of Patient)

_____ (Witness)
_____ (Substitute Decision Maker)

(Relationship to Patient)