

CONSENT FOR CLINIC, TREATMENT AND/OR INVESTIGATIONS

1. CONSENT TO TREATMENT

I,
(name in full) hereby consent to, authorize and request the attending physician or physicians of the Shriners Hospitals for Children, Canada, to perform the necessary treatment and/or investigations to
(name of patient)

2. CONSENT TO ANAESTHETIC

I hereby consent to, authorize and request the administration of such local anaesthetics as may be considered necessary by the physician.

3. CONSENT TO PHOTOGRAPHS AND VIDEOS

I hereby consent to and authorize the taking of photographs or the filming of videos with the understanding that the same are to be used for medical, educational or scientific purposes.

4. I understand that this is a University Affiliated Hospital. This may involve the child's illness and his treatment being explained to doctors-in-training and hospital Staff Trainees. Also, the child may be examined and treated by them under the direction of senior members of the Hospital staff, and I give my consent thereto.

I agree that I have read and fully understand the above consent, that all statements requiring completion were completed prior to my signing, and that all deleted or added paragraphs have been initialed by me.

.....
Date

.....
Legal Guardian

.....
Witness

.....
Date

.....
Patient over 14 years old

.....
Witness



Hôpitaux Shriners
pour enfants
Shriners Hospitals
for Children™

APPLICATION FOR TREATMENT

APPLICATION No.: _____ HOSPITAL No.: _____ CODE No.: _____

PLEASE PRINT

Last name										First Name									
Number					Street														
City										Province or State					Postal Code or Zip Code				
Telephone Number (Home) ()					Telephone Number (Work) ()					Telephone Number (Other) ()									
Sex		Place of Birth			Date of birth (Yr/Mth/Day)			Health Insurance No.					Exp. Date						
Name of Father										Maiden Name including first name of mother									
Legal guardian of child																			
Legal guardian - address										Telephone (Home): ()					Telephone (Office): ()				
City										Province or State					Postal Code or Zip Code				
Montreal Children's Hospital Chart No.										Ste-Justine's Hospital Chart No.									

FOR HOSPITAL USE ONLY:

RESUMÉ OF MEDICAL RECORDS REQUESTED

Diagnosis and clinical data: *(For use by referring physician)*

SECOND OPINION

Referring physician										Date of Application												
Address					Postal Code					Attending Physician												
Telephone ()										Referring Shriner												
PATIENT REFERRAL SOURCE:										Address					Postal Code							
Physician <input type="checkbox"/>		Shriners <input type="checkbox"/> Temple _____			Family/Self <input type="checkbox"/>			Friend <input type="checkbox"/>					School/Teacher <input type="checkbox"/>					Poster/Flyer <input type="checkbox"/>				
Other Health Care Worker <input type="checkbox"/>		Radio <input type="checkbox"/>			Newspaper <input type="checkbox"/>			Television <input type="checkbox"/>					Billboard <input type="checkbox"/>					Other (Specify): _____				
										Telephone: ()												