CONSENT TO TREATMENT

Doctor’s Name: A. Ralph-Edwards

Treatment:
Use of medical records in formulation of case report
No information identifying Mr. Kent was disclosed.

Your doctor has proposed this treatment. You have the right to decide whether to accept this treatment or not. If there is anything you do not understand, ask the doctor or health practitioner.

The doctor or health practitioner has fully explained to me:
- what the treatment is;
- why the treatment is needed;
- how the treatment may benefit me;
- what risks and side effects are possible;
- what other choices for treatment I have; and
- what may happen if I do not have the treatment.

I have had the chance to ask questions, which were answered to my satisfaction.

I agree that the doctor or health practitioner(s) may perform all procedures that:
- need to be done before treatment starts;
- become medically necessary during treatment; and
- in exceptional cases, may allow other qualified health practitioners to do all or part of the treatment and make decisions about my care.

The University Health Network is a teaching hospital. I agree that health practitioners in training or visiting may watch my treatment, under the supervision of a fully-trained health practitioner.

I agree that health practitioners in training may participate in my treatment under the supervision of a fully-trained health practitioner.

I agree that my treatment (including x-rays and tissue samples) may be photographed, videotaped or electronically recorded for teaching or research purposes, as long as my identity remains unknown.

If you agree to the proposed treatment, please sign this form. You have the right to change your mind at any time, even after signing this form.

Date: 27/11/2016

Name of Patient: Borden Kent

Signature of Patient: Borden Kent

Name of Interpreter (Please Print) Signature of Interpreter

TO BE COMPLETED BY DOCTOR/HEALTH PRACTITIONER

(N.B. Failure to complete this portion of the Consent Form and Consent for Future Research Form attached hereto (Form 2019K) may result in the withholding of treatment to this patient.)

I confirm that I have explained the nature of the treatment(s), expected benefits, material side effects, the material risks, special or unusual risks, alternative courses of action as well as the likely consequences of not having the treatment and answered all questions.

Date: 27/11/2016

Health Practitioner