MARKHAM STOUFFVILLE HOSPITAL CORPORATION

381 Church Street
P.O.Box 1800
Markham, Ontario L3P 7P3

☐ Markham Site ☐ Uxbridge Site

OBSTETRICAL CONSENT TO TREATMENT

Name of Patient: _____

1. I consent to those treatments/procedures/operations deemed necessary which reflect responsible management of my pregnancy/labour/birth/postpartum care. The consent includes the routine and emergency care of my newborn baby/babies.

2. I further agree that the practitioner below may assign other surgeons, physicians, midwives and hospital staff to perform all or part of the investigation, treatment or operative procedures. I also agree that they shall have the same discretion in my investigation and treatment.

3. I understand that Markham Stouffville Hospital has teaching commitments and various healthcare personnel may be involved in my care during the Hospital stay.

4. If it is determined to be medically advisable during the course of my treatments/procedures/ operations, I give my consent to the administration of anaesthetics/pain medication including, but not limited to local, regional (e.g., epidural) or general anaesthetic.

5. I request and expect that in a situation where additional procedures may be deemed necessary, (e.g. a Caesarean section, forceps birth, vacuum birth) every opportunity will be taken to explain the circumstances to me and my support person insofar as time and safety permits.

6. In compliance with provinical legislation, I acknowledge that the hospital may utilize tissue specimens removed during my procedures for research and/or teaching purposes.

7. The possibility of the administration of blood or blood products including Rho(D)Immune Globulin (RhIG) has been fully discussed with me, and a consent or refusal form for blood or blood products has been completed as per this discussion.

8. I confirm that I have had ample opportunity to raise questions concerning the expected benefits and material side effects of treatment/procedures/operation involved in the management of my pregnancy/labour/birth/postpartum care and the routine care of my newborn baby/babies. I confirm that I understand, accept and am satisfied with the explanations provided.

_____ _____

Signature of Patient
(or Substitute Decision Maker, if applicable)

Name of Substitute Decision Maker, if applicable

_____ _____

Signature of Physician/Midwife

Date