Keele Street Surgery
P: 365-418-8780
F: 905-918-0961
reception@keelestreetsurgery.ca

INSTRUCTIONS FOR YOUR COLONOSCOPY

PROCEDURE LOCATION: Mackenzie Health Hospital, 10 Trench Street, Richmond Hill

PROECDURE DATE: _____

ARRIVAL TIME: _____

PROCEDURE TIME*: _____

- Upon arrival at hospital, go to **PATIENT REGISTRATION** (main flr) for self check-in
- Once you have registered, go to **5th floor ENDOSCOPY UNIT**
- It is **MANDATORY** to arrange for a responsible adult who can pick you up after your procedure and bring you home. You cannot use a taxi, Uber, or public transportation, unless you are accompanied by a responsible adult. If you do not have this arranged on the day of your procedure, your procedure will be cancelled, as per hospital policy.
- You CANNOT drive a vehicle or operate heavy machinery for 24 hours after your procedure, due to the potential side effects of the sedative given.
- You will be at the hospital for a total of 3 to 4 hours (procedure is 30 minutes)

Please keep in mind that each patient's procedure can vary in length of time – the colonoscopy takes as long as it takes to do a thorough examination. Therefore, your procedure may not start at the exact time listed above. Your understanding and patience are appreciated.

COLONOSCOPY BOWEL PREP MATERIALS

- Bowel preparation solution:
  - Peglyte solution (4 litres)
  - Alternative: Moviprep solution (2 litres - lower volume)
- Bisacodyl (Dulcolax) 5 mg – you will need 3 tablets (oral tablet, NOT suppository)
- Simethicone (Ovol) 125 mg – you will need 4 tablets
- Clear liquid of your choosing: water, apple juice, WHITE grape juice, vitamin water, soda, black tea or coffee (NO milk or cream), clear broth, Jello, Gatorade, Pedialyte (avoid RED or PURPLE liquids) – you will need 3 litres total volume

TO DO ONE WEEK BEFORE YOUR COLONOSCOPY:

- ☐ Read these instructions carefully and fully
- ☐ Notify your surgeon's office if you are on a blood thinner medication or OZEMPIC
- ☐ Do not eat any nuts or seeds for 7 days before your procedure
- ☐ Arrange to have someone be your ride to and from the hospital
- ☐ Purchase the above listed bowel prep materials

CANCELLATION POLICY

To cancel or reschedule an appointment, you must provide at least 3 business days' notice. Our late cancellation & no-show fee is $200.00. Appointments cannot be re-scheduled until outstanding fees for missed appointments are paid.

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SPLIT DOSE BOWEL PREP INSTRUCTIONS

The purpose of the bowel prep is to clean your colon. The cleaner your colon is prior to your procedure, the more successful the procedure will be. Please follow this timeline on how and when to take the bowel preparation.

THE DAY BEFORE YOUR COLONOSCOPY:

- **Drink only clear liquids the entire day. DO NOT EAT ANY SOLID FOOD.**
  - Examples of clear liquids: water, apple juice, white grape juice, vitamin water, soda, black tea or coffee (no milk or cream), clear broth, jello, Gatorade
  - Avoid any red or purple liquids, avoid any juice with pulp
- Drink lots of liquids throughout the day – aim to drink at least 1 cup (~250 ml) of liquid per hour while you are awake. It is important to stay hydrated.
- **At 5:00pm:** Take the 3 Bisacodyl tablets with water.
- **At 8:00pm:** Take the first 2 L of Peglyte. Aim to drink one cup (250ml) every 15 minutes. It will take you 2 hours to finish the mixture. If you feel crampy or nauseous, take a break for 30 minutes. Once you finish the Peglyte, take Simethicone 2 tablet (125mg each).

THE MORNING OF YOUR COLONOSCOPY:

- **At 5 hours before your scheduled procedure time:** Take the second 2L of Peglyte. Once you finish the Peglyte, take Simethicone 2 tablets (125mg each).
- If your bowel movements are still brown or murky after drinking the bowel prep, please continue to drink 1-2 litres more of clear liquids of your choosing - the goal is to have bowel movements coming out as clear pale yellow water before your procedure.
- You may drink clear fluids up to 3 hours prior to your scheduled procedure time. After that, **NOTHING AT ALL BY MOUTH** (solid or liquid) until after the procedure is done.

This schedule may require you to wake up at a very early or inconvenient time. However, this ‘split dose’ bowel prep schedule gives you the *best* prep outcome for the most successful procedure.

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SPECIAL CONSIDERATIONS

IF YOU ARE DIABETIC:

- Make sure you check your blood sugar levels frequently the day before and the day of your procedure (i.e. every 4 hrs and before bedtime and upon waking)
- Take a sugary drink immediately if your blood glucose drops below 4
- If you are taking oral medication (metformin, glyburide etc.) only take them in the morning the day before the procedure and resume them only once you are eating solid food at your regular scheduled times the day of the procedure
- Insulins are to be taken at ½ the normal dose during the preparation day and should be omitted on the procedure day

IF YOU ARE ON OZEMPIC OR OTHER GLP-1 AGONIST:

- Please let your surgeon know if you are taking any of the following medications:
  - **Semaglutide (Ozempic, Wegovy)**
  - **Tirzepatide (Mounjaro, Zepbound)**
  - **Dulglutide (Trulicity)**
  - **Liraglutide (Victoza)**
- These medications MUST be stopped up to TWO WEEKS prior to procedure.
- If you have not adequately held this medication prior to procedure, your procedure may be cancelled.

IF YOU ARE ON A BLOOD THINNER:

Please notify your surgeon's office if you are on a blood thinner, and follow the chart below to decide if and when you need to hold this medication:

Blood thinner type	Examples	What to do
Coumadin	Also called warfarin	Stop **5 days** prior to procedure
Antiplatelet	Plavix (clopidogrel) or Brillinta (ticagrelor)	Stop **5 days** prior to procedure
New oral anticoagulants	Xarelto, Eliquis, Pradaxa, apixaban, rivaroxaban, dabigatran	Stop **2 days** prior to procedure
Aspirin	81mg	You may continue

OTHER CONDITIONS

Please let your surgeon know if you have the following conditions ahead of time:

- Any heart condition – this will let your surgeon determine if you need any special considerations before your procedure
- A pacemaker – make sure you bring your pacemaker ID number with you on the day of the procedure
- A replacement heart valve, for which antibiotics are sometimes required before procedure
- History of strokes or mini strokes (TIAs)

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INSTRUCTIONS FOR YOUR GASTROSCOPY

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PROECDURE DATE: _____

ARRIVAL TIME: _____

PROCEDURE TIME: _____

- Upon arrival at the hospital, please first report to PATIENT REGISTRATION (main floor) for self check-in process
- Once you have registered, go to the 5th floor ENDOSCOPY UNIT
- You will be at the hospital for a total of 3 to 4 hours (procedure is 30 minutes)
- It is **MANDATORY** to arrange for a responsible adult who can pick you up after your procedure and bring you home. You cannot use a taxi, Uber, or public transportation, unless you are accompanied by a responsible adult. If you do not have this arranged on the day of your procedure, your procedure will be cancelled, as per hospital policy.

THINGS TO DO BEFORE YOUR GASTROSCOPY:

- ☐ Read all these instructions carefully and thoroughly
- ☐ If possible, STOP antacid medications 2 weeks before the procedure.
  - Examples of antacid medications:
- ☐ Notify your surgeon's office if you are on a blood thinner medication
- ☐ Arrange to have someone be your ride to and from the hospital
- ☐ Note: You will NOT be fit to operate heavy machinery or drive a car for 24 hours after the procedure due to the sedation.

THE MORNING OF YOUR GASTROSCOPY:

- You may drink clear fluids only (no solid food) until 4 hours prior to your appointment time
  - Examples of clear liquids: water, apple juice, white grape juice, vitamin water, soda, black tea or coffee (no milk or cream), clear broth, jello, Gatorade
- After that, **NOTHING AT ALL BY MOUTH (solid or liquid) UNTIL AFTER YOUR PROCEDURE IS DONE.**

CANCELLATION POLICY

To cancel or reschedule an appointment, you must provide at least 3 business days' notice. Our late cancellation & no-show fee is $200.00. Appointments cannot be re-scheduled until outstanding fees for missed appointments are paid.

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SPECIAL CONSIDERATIONS

IF YOU ARE DIABETIC:

- Make sure you check your blood sugar levels frequently the day before and the day of your procedure (i.e. every 4 hrs and before bedtime and upon waking)
- Take a sugary drink immediately if your blood glucose drops below 4
- If you are taking oral medication (metformin, glyburide etc.) only take them in the morning the day before the procedure and resume them only once you are eating solid food at your regular scheduled times the day of the procedure
- Insulins should be omitted on the procedure day

IF YOU ARE ON OZEMPIC OR OTHER GLP-1 AGONIST:

- Please let your surgeon know if you are taking any of the following medications:
  - **Semaglutide (Ozempic, Wegovy)**
  - **Tirzepatide (Mounjaro, Zepbound)**
  - **Dulglutide (Trulicity)**
  - **Liraglutide (Victoza)**
- These medications MUST be stopped up to TWO WEEKS prior to procedure.
- If you have not adequately held this medication prior to procedure, your procedure will be cancelled, as per hospital policy.

IF YOU ARE ON A BLOOD THINNER:

Please notify your surgeon's office if you are on a blood thinner, as you may need to hold this medication a few days before the procedure.

OTHER CONDITIONS

Please let your surgeon know if you have the following conditions ahead of time:

- Any heart condition – this will let your surgeon determine if you need any special considerations before your procedure
- A pacemaker – make sure you bring your pacemaker ID number with you on the day of the procedure
- Any heart valves for which antibiotics are required before procedures
- History of strokes or mini strokes (TIAs)

Colonoscopy: Patient Information Sheet

What is a colonoscopy?

A colonoscopy is a medical test that lets a doctor look inside your large intestine (also called the colon). The doctor uses a long, thin, flexible tube with a small camera and light on the end. This tube is gently passed through the rectum into the colon.

The test helps doctors: - Look for causes of bowel symptoms (such as bleeding, pain, or diarrhea) - Check for polyps (small growths) - Screen for colon cancer - Remove polyps or take small tissue samples (biopsies) if needed

Why do I need a colonoscopy?

You may need a colonoscopy to: - Find the cause of blood in your stool - Investigate changes in bowel habits - Check abdominal pain or unexplained weight loss - Screen for colon cancer (even if you feel well) - Follow up on previous test results

How do I prepare for the test?

Your bowel must be completely clean so the doctor can see clearly.

Preparation usually includes: - A special diet (often clear liquids) the day before - Drinking a bowel-cleansing solution to empty your bowels - Stopping or adjusting certain medications (your doctor will tell you which ones)

Good preparation is very important. If the bowel is not clean, the test may need to be repeated.

What happens during the procedure?

- You will change into a hospital gown
- You will usually be given medication through a vein to help you relax or sleep
- The procedure usually takes 20–45 minutes
- Most people feel little or no pain

Air or gas is gently put into the colon to help the doctor see. This may cause some pressure or bloating.

What happens after the procedure?

- You will rest until the medication wears off
- You may feel bloated or pass gas for a short time
- You will need someone to take you home
- You should not drive, drink alcohol, or make important decisions for 24 hours

Your doctor will explain the results to you. If biopsies were taken, results may take a few days.

What are the risks of a colonoscopy?

A colonoscopy is generally very safe, but all medical procedures have some risks.

Common and mild risks

- Bloating or gas
- Mild cramping
- Temporary discomfort

Less common but more serious risks

- **Bleeding:** This can happen if a polyp is removed or a biopsy is taken. It is usually minor but may rarely require treatment.
- **Tear or hole in the bowel (perforation):** This is rare, but serious. It may require surgery.
- **Reaction to sedation:** Some people may have breathing or heart-related reactions to the medication.
- **Infection:** Very rare, but possible.

Your doctor believes the benefits of the test are greater than these risks.

When should I seek medical help after the test?

Call your doctor or go to the emergency department if you have: - Severe or worsening abdominal pain - Heavy bleeding from the rectum - Fever or chills - Dizziness, weakness, or fainting

Questions or concerns

If you have questions about the procedure, preparation, or risks, please speak with your doctor or nurse. They are happy to help.

This information is meant to help you understand your colonoscopy. It does not replace medical advice from your healthcare provider.

Gastroscopy: Patient Information Sheet

What is a gastroscopy?

A gastroscopy (also called an upper endoscopy) is a medical test that allows a doctor to look inside your upper digestive tract. This includes the esophagus (food pipe), stomach, and the first part of the small intestine (duodenum).

The doctor uses a thin, flexible tube with a small camera and light on the end. The tube is gently passed through your mouth and down your throat.

Why do I need a gastroscopy?

You may need a gastroscopy to: - Find the cause of stomach pain or heartburn - Investigate nausea, vomiting, or difficulty swallowing - Check for bleeding or anemia - Look for ulcers, inflammation, or infection - Take small tissue samples (biopsies) - Follow up on abnormal imaging or test results

How do I prepare for the test?

Your stomach must be empty so the doctor can see clearly.

Follow the instructions carefully. If your stomach is not empty, the test may need to be delayed.

What happens during the procedure?

- You will change into a hospital gown
- Your throat may be sprayed with a numbing medication
- You may receive medication through a vein to help you relax or sleep
- The procedure usually takes 5–15 minutes

You will lie on your side. A small mouth guard is placed to protect your teeth. The tube does not interfere with breathing.

What happens after the procedure?

- You will rest until the medication wears off
- Your throat may feel sore or numb for a short time
- Do not eat or drink until the numbness has worn off
- You will need someone to take you home if you received sedation
- Do not drive, drink alcohol, or make important decisions for 24 hours

Your doctor will explain the results. Biopsy results may take a few days.

What are the risks of a gastroscopy?

A gastroscopy is generally very safe, but all medical procedures have some risks.

Common and mild risks

- Sore throat
- Bloating or gas
- Mild nausea
- Temporary discomfort

Less common but more serious risks

- **Bleeding:** This may occur if a biopsy is taken or treatment is performed. It is usually minor.
- **Tear or hole in the digestive tract (perforation):** Rare, but serious. Surgery may be needed.
- **Reaction to sedation:** Breathing or heart-related reactions can occur.
- **Infection:** Rare, but possible.

Your doctor believes the benefits of the test are greater than these risks.

When should I seek medical help after the test?

Call your doctor or go to the emergency department if you have: - Severe or worsening chest or abdominal pain - Vomiting blood or black stools - Fever or chills - Trouble swallowing that gets worse - Dizziness, weakness, or fainting

Questions or concerns

If you have questions about the procedure, preparation, or risks, please speak with your doctor or nurse.

This information is meant to help you understand your gastroscopy. It does not replace medical advice from your healthcare provider.

Mackenzie Health

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10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Health Card Number:

Date of Birth:

Preoperative Anaesthetic Questionnaire

Part I – For all Surgery Programs Patients
To be completed by patient or family member

Date: _____(dd/mm/yyyy)

Name: _____

Height: _____ cm ☐ ft/in ☐ **Weight:** _____ kg ☐ lb ☐

Languages Spoken: _____

Do you need an interpreter to communicate with your care providers? Yes ☐ No ☐

1.) List of all operations during which you were given a general or other type of anaesthetic:

a) Within one year _____

b) Over one year_____

_____

2.) Do you or have you been told if you have any of the following? Please answer all questions below.

Anesthesia History	Yes	No	Comments
Provider told you that you are hard to intubate			
Nausea and vomiting following sedation			
Malignant hyperthermia			
Headaches after an epidural or spinal anesthesia treatment			
Remained aware of your surroundings once you were sedated			
Pseudocholinesterase deficiency or succinylcholine sensitivity			
Delayed awakening from anesthesia			
Motion sickness			
Sleep apnea			
Have you ever had a reaction to a local/general anaesthetic? Please describe the reaction.			
Has anyone in your family had a reaction to a local/general anaesthetic? Please describe the reaction they had.			
Is there anything else that you would like to tell your anaesthesiologist?			

3) Do you have any drug allergies: Yes ☐ No ☐ **If yes, please fill in the information below**.

Drugs	Type of Reaction	Drugs	Type of Reaction

4.) Are you allergic to LATEX? Yes ☐ No ☐ Don't know ☐ **(nurse to confirm)**

5.) List of any other non-drug allergies (e.g. Grass, Pollen) _____

6.) List of your medications including nonprescription or herbal remedies:

Medication	How much are you taking	How often?	Last Taken (date/time)	

Patient label

Preoperative Anaesthetic Questionnaire

7.) Are you on blood-thinning medications (prescribed or natural)? If yes, please indicate which medications.
Yes ☐ No ☐ (If yes, list the medication and state when stopped) _____

8.) Do you smoke or have you ever smoked? Yes ☐ No ☐
If yes, state amount of cigarettes/cigar you smoke per day _____ and for how many years _____
If you stopped, when? _____

9.) Have you ever, or do you currently use nicotine e-cigarettes? Note that cannabinoid vaping will be asked in the Marijuana/Cannabinoids section. Yes ☐ No ☐

- How often are you using e-cigarettes? (i.e. daily ☐ weekly ☐) _____
- How many times do you refill your vape per week? _____
- What type of substances do you use? (i.e. Nicotine ☐ Flavour ☐) _____
- If you stopped, when? _____

10.) Do you use any recreational drugs? Yes ☐ No ☐

- Have you ever, or do you currently use marijuana or cannabinoids? Yes ☐ No ☐
- How often are you using marijuana/cannabinoids? _____
- What method(s) do you use? _____
- What substances do you use? THC ☐ CBD ☐
- If you use any other substances, please state them. (i.e. cocaine, heroin, fentanyl) _____
- Describe, on average, how much you use weekly? _____
  Comments _____

11.) Do you or did you drink alcohol/beer daily? Yes ☐ No ☐ If yes, state the amount per day _____
If you stopped, when? _____

12.) Do you have any loose, capped or false teeth? If yes, check which and state which tooth (teeth)
loose ☐ capped ☐ false teeth ☐ Other ☐ _____

13.) Have you ever been diagnosed with any of the following condition?
********Please answer every question listed below.***

Condition	**Yes**	**No**	**Don't know**	**Comments (for example when were you diagnosed)**
Chronic bronchitis				
Pneumonia				
Shortness of breath				
Asthma				
COPD/Emphysema				
Any other conditions that affect your breathing?				
Frequent headaches				
Migraines				
Dizziness				
Stroke				Residual deficits? Yes ☐ No ☐
Seizures				How often? _____
Anxiety				
Any other conditions that affect your nervous system?				
Chronic back pain				
Chronic neck pain				
Arthritis				
Temporomandibular Joint Syndrome (TMJ)				
Any other conditions that affect your bones?				
Any other conditions that affect your muscles?				

Patient label

Preoperative Anaesthetic Questionnaire

Condition	Yes	No	Don't know	Comments (for example when were you diagnosed)
Anemia				
Thalassemia				
Sickle cell				Disease ☐ Carrier ☐
Chest pain (angina)				
High blood pressure				
Heart disease				
Heart attack				
Heart Failure				
Irregular heart beat				
Heart murmur				
Do you have a pacemaker?				
Blood clot				Leg ☐ Long ☐
Blood clot in lungs				
Bleeding tendency				
Past blood transfusion?				If so, any reaction? Yes ☐ No ☐
Hiatal hernia				
Peptic ulcer				
Heart burn/acid reflux/GERD				
Crohn's / Colitis/ IBS				
Hepatitis				A ☐ B ☐ C ☐
Liver problems				
Diabetes				Insulin ☐ Pill ☐ Diet ☐
Thyroid condition				
Kidney failure				
Dialysis treatment				Hemodialysis ☐ Peritoneal Dialysis ☐
Any other conditions that affect your bladder?				
Any other conditions that affect your kidneys?				
HIV/AIDS				
Tuberculosis				
Cancer – Where? _____				Chemotherapy ☐ Radiation ☐
Are you pregnant?				How many weeks?_____
Other				

14.) Are you currently being cared for by any specialists? (i.e., endocrinologist, cardiologist, etc.). If yes, please state the specialist's name, specialty and contact information.

Specialist Name:_____ Specialty: _____ Telephone: _____

Specialist Name:_____ Specialty: _____ Telephone: _____

Specialist Name:_____ Specialty: _____ Telephone: _____

15.) Have you ever been on Isolation precautions when in hospital? Yes ☐ No ☐ If yes, when _____

What were the infections? (i.e., MRSA, VRE)_____

16.) If your life is in danger because of severe blood loss, will you accept a transfusion of blood, its components or products? Yes ☐ No ☐ If the answer is "No", please tell your surgeon **before** the day of surgery.

17.) If you are having surgery today, please state what time you last ate any food or drank any fluids, including water?
Food: Time _____ Date_____(dd/mm/yyyy) **Drink:** Time _____ Date: _____(dd/mm/yyyy)

18.) Has someone assisted with completing with this form? Yes ☐ No ☐

Name: _____ Telephone Number: _____
(Name of person completing the form)

Signed: _____ Date: _____ Relationship to patient: _____
(Signature of person completing the form) (dd/mm/yyyy) (if applicable)

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CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION

Treatment/Operation/Test: *(Do not use abbreviations – write out in full)* _____
Gastroscopy, and Colonoscopy

I consent to the proposed operative procedure(s), treatment(s) or test(s) described above.

I confirm that the anticipated nature, benefits, risks and side effects of the above have been explained to me, including the anticipated nature, benefits, risks and side effects of any alternative course(s) of action and likely consequences of not having the treatment/operation/test. I understand that other qualified individuals may assist in the treatment/operation/test, this may include qualified medical learners. Any questions I have asked have been answered to my satisfaction.

_____	_____	_____
Signature of Patient/SDM	PRINT NAME	Date (dd/mm/yyyy)

_____
If signed by SDM, state of relationship to patient

If patient is a U.S. or foreign resident, please complete Jurisdiction of Medical Liability Waiver on the reverse of this form

I have read/interpreted/communicated the above consent to treatment information for the patient/SDM.

_____	_____
Signature of Interpreter (if required)	PRINT INTERPRETER'S NAME

TELEPHONE CONSENT

I confirm that I have explained by telephone to _____ the nature of
Name of Substitute Decision Maker

the stated treatment(s), operative procedure(s), or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and the likely consequences of not having the treatment/operation/test and have answered all their questions.

_____	_____	_____
Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)
_____	_____	_____
Signature of 3rd Party of Telephone Consent	PRINT NAME	Date (dd/mm/yyyy)

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) as stated on the reverse of this consent because the patient meets the Conditions for Emergency Treatment without Consent as outlined in **Mackenzie Health's Consent to Treatment Policy** and the **Health Care Consent Act.**

_____	_____	_____
Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)

TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE TREATMENT

(N.B. Failure to complete this section of the consent form may result in the withholding of treatment to this patient.)

I confirm that I have explained the nature of the above operative procedure(s), treatment(s) or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and likely consequences of not having the treatment(s) to the above patient / substitute decision maker and answered all their questions.

_____	_____	_____
Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)

CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION (Continued)

JURISDICTION OF MEDICAL LIABILITY WAIVER FOR TREATMENT OF U.S. AND OTHER FOREIGN RESIDENTS

I agree that the relationship between myself and Mackenzie Health, its staff, delegates, physicians and other independent health care practitioners providing medical or other health care and treatment to me shall be governed by and construed in accordance with the laws of the Province of Ontario. I acknowledge that the Courts of the Province of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action. I hereby agree that I will commence any such legal proceedings in the Province of Ontario and I hereby submit to the exclusive jurisdiction of the Ontario Courts.

_____ _____ _____

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

I have read/interpreted/communicated the above information regarding the Jurisdiction of Medical Liability Waiver to the patient/SDM.

_____ _____

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME

BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS ☐ NOT APPLICABLE

☐ **Electronic blood consent obtained for this encounter**

I consent to receive donor blood and/or blood products manufactured from donor blood.
I acknowledge that the benefits and risks of receiving a donated unit of blood, including blood products manufactured from donor blood, have been discussed with me and all questions have been answered to my satisfaction. I have received the "Patient Information on Transfusion" brochure.

_____ _____ _____

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

_____

If signed by SDM, state relationship to patient

I have read/interpreted/communicated the above information regarding blood and blood products to the patient/SDM.

_____ _____

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME