Manitoba

Department of Families

Manitoba Developmental Centre
P.O. Box 1190
Portage la Prairie MB R1N 3C6
CANADA

Treatment Room Nurse
Phone : (204)856-4279
Fax : (204)856-4352

CONSENT FOR MEDICAL TREATMENT & PROCEDURES

- ☐ Surgical Procedure
- ☐ Medical Treatment
- ☐ Immunization
- ☐ Diagnostic Investigation
- ☐ Blood Products
- ☐ Other

RE: _____ DB: _____
Resident's Name Birthdate

I/We _____
Print name of SDM(s) for Personal Care **or** Resident's Name

Agree that Dr. _____ and/or his/her assistant may do the following:
Print Doctor's Name

_____

_____

1) The procedure has been explained in lay terms by Dr./Nurse. _____
Print Physician/Nurse's Name

2) I understand the purpose, nature, expected outcomes and potential complications of the proposed procedure, as well as the alternatives and consequences of not doing the proposed procedure.

Resident or Substitute Decision-Maker (SDM) Consent

☐ ***Verbal/Telephone Consent (Witness required)***

Resident or SDM Name and/or Signature & Relationship	Date	Time
Joint SDM Name and/or Signature & Relationship (if applicable)	Date	Time
Physician/Nurse Name and/or Signature	Date	Time
Witness Name and/or Signature & Relationship	Date	Time