NORTH YORK ENDOSCOPY CENTRE

2 CHAMPAGNE DRIVE, UNIT B19 TORONTO, ON M3J 2C5
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Consent to Investigation, Treatment or Operation

I, _____ consent to undergo the following investigation,
Name of Patient
treatment or operation which may include the use of anesthetics as needed.

☐ Gastroscopy ☐ Colonoscopy ☐ Gastroscopy and Colonoscopy

This is ordered by or performed by: Dr. _____
Name of Health Practitioner

I received an explanation of:

- the investigation, treatment or operation and the usual effects,
- the significant risks involved, and
- Other choices available to me.

My questions have been answered. I am satisfied with the explanations and understand them.

I also agree to the following:

1. Additional or other investigations, treatments or operations that the health practitioner feels are needed immediately.
2. The use of blood, blood products or tissue.
3. The help of other doctors and assistants as may be necessary. They may order or perform all or part of the investigation, treatment or operation using the same care as the health practitioner.
4. I am responsible to inform the health practitioner prior to my procedure of any dental issues, including but not limited to any loose teeth, denture or braces. I understand that North York Endoscopy Centre will not be held responsible for any dental damages caused by or resulting from the investigations, treatments or operations.

COVID-19 Addendum: I recognize that the physicians and staff at North York Endoscopy Centre are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is a risk of becoming infected with COVID-19 by virtue of attending a health care premises and proceeding with this procedure. I hereby acknowledge and assume any risk of becoming infected with COVID-19, and I give my express permission for my physician and all the staff at North York Endoscopy Centre Inc. to proceed with the same.

_____ _____
Date (Day/Month/Year) Signature of Patient (or Substitute Decision Maker)

_____ _____
Print Name of Translator (if required) Signature of Proposer of Treatment

_____ _____
Witness Name printed Witness signature

Version date: June 2, 2020