



NORTH YORK GENERAL

# CONSENT TO TREATMENT

FORM 1569

O - 06/96  
Rev. 03/2015

1. I, \_\_\_\_\_ hereby authorize  
PRINT name of patient or substitute decision maker

\_\_\_\_\_ and such physicians, surgeons, anesthesiologists and other  
PRINT name of physician or health practitioner  
**health practitioners whose services are required, to perform the following treatment(s) and/or investigation(s):**  
(no abbreviations; where appropriate indicate side of the patient)

\_\_\_\_\_  
\_\_\_\_\_

upon \_\_\_\_\_  
PRINT name of patient

- 2. I agree that the nature of the treatment(s) and/or investigation(s), the expected benefits, material risks/side effects and the likely consequences of refusing treatment have been explained to me in a manner that I understand. All my questions regarding the treatment(s) and/or investigations have been answered to my satisfaction.
- 3. If any unexpected conditions are discovered during the above treatment(s) and/or investigation(s), I consent to such treatment(s) and/or investigation(s) which may be essential for the maintenance of life or vital function in addition to or in place of those authorized above.
- 4. I understand that, if I receive an anesthetic, it is my responsibility to refrain from driving a motor vehicle and avoid alcohol and sedatives for 24 hours.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date dd / mm / yy

\_\_\_\_\_  
Signature of Substitute Decision Maker (SDM)

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date dd / mm / yy

### STATEMENT OF PHYSICIAN / HEALTH PRACTITIONER (HP)

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

\_\_\_\_\_  
Signature of Physician / HP

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Date dd / mm / yy

### EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) and/or investigation(s), identified on this consent because the patient meets the Conditions for Emergency Treatment without Consent outlined in the Health Care Consent Act (1996) and the North York General Hospital Consent to Treatment Policy II-50 s. 13.

\_\_\_\_\_  
Signature of Physician / HP

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Date dd / mm / yy

**INTERPRETER DECLARATION**

I have interpreted the conversation between \_\_\_\_\_ Physician / HP  
and \_\_\_\_\_ Patient / SDM Date dd / mm / yy

\_\_\_\_\_  
Signature of Interpreter

\_\_\_\_\_  
PRINT NAME

**TELEPHONE CONSENT**

I confirm that I have explained by telephone, the nature of the treatment(s) and/or investigation(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatment(s) to:

\_\_\_\_\_ and answered all questions.

\_\_\_\_\_  
Substitute Decision Maker

\_\_\_\_\_  
Signature of Physician / HP

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Date dd / mm / yy

\_\_\_\_\_  
Signature of Third Party

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Date dd / mm / yy



**NORTH YORK GENERAL**  
**PATIENT QUESTIONNAIRE**  
**DEPARTMENT OF ANAESTHESIA**

**PATIENT to complete this form**  
**and fax to 416-748-8582.**

*Failure to fill out this form  
 completely may delay your surgery.*

FORM 1677

REV. 9/08

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN	HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Heart Disease/Heart Attack/Chest Pain					Severe Snoring/Sleep Apnea				
High Blood Pressure					Stroke / "ministroke" / TIA				
Shortness of Breath					Chronic Pain				
Recent Cough/Cold					Acid Reflux/Ulcer				
Asthma/Wheezing					Back Problems				
Glaucoma					Thyroid Problems				
Epilepsy					Blood Thinners/Aspirin				
Hepatitis/Jaundice/HIV					Joint Replacement				
Bleeding Problems/Clotting Problems					Artificial Body Parts				
Kidney Problems					Difficulty Opening Mouth				
Diabetes					Difficulty Moving Neck				
Blood Transfusion					Rheumatoid Arthritis				
Reaction to Local/General Anaesthetic					Cortisone/Prednisone				
Do you wear Contact Lenses?					<b>Medications you take including Vitamins/Herbals:</b>				
Do you have Caps, Bridges, Crowns, Dentures, Loose Teeth?						Dose	Frequency		
Is there a Family History of Problems with Anaesthetic?									
List previous operations or admissions to a hospital. When?									
Have you seen a Specialist in the last 5 years? Name and phone #:					Do You have any Allergies to any Food Medicine or Latex? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes - What?				
<input type="checkbox"/> Heart Doctor (Cardiologist):									
<input type="checkbox"/> Lung Doctor (Respirologist):									
<input type="checkbox"/> Nerve Doctor (Neurologist):									
Possibility of pregnancy: No <input type="checkbox"/> Yes <input type="checkbox"/>					<b>To be completed by nurse on day of surgery:</b>				
Cigarettes per Day:			Ounces Alcohol per Week:		Time of Last Fluids:		Time of Last Food:		
Recreational/Street Drugs:									
Did You have or ever had any of the following Tests: When?					Pre-Admit Nurse:		Date:		
<input type="checkbox"/> Exercise Stress Test (Treadmill):					Day of Surgery Nurse:		Date:		
<input type="checkbox"/> Nuclear Medicine Stress Test (Mibi):					Comments:				
<input type="checkbox"/> Angiogram/Angioplasty:									
<input type="checkbox"/> Ultrasound of Heart (Echo):									
<input type="checkbox"/> Holter Monitor:									
<input type="checkbox"/> Lung Function:									

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## ADMISSION INSTRUCTIONS

Your surgery date for your \_\_\_\_\_ eye is: \_\_\_\_\_  
Your surgery date for your \_\_\_\_\_ eye is: \_\_\_\_\_

**\*Please note that your surgery time will be given to you 1 week prior to your surgery\***

**Arrival Time:** \_\_\_\_\_ **Surgery time may change. You will be contacted in advance if a time change is required.**

On arrival, please go directly to the Main Entrance of the hospital to the Patient Registration Desk. You will be required to pay for any premium lens fee if you have decided to upgrade your lens. After registration, please proceed to the 3<sup>rd</sup> Floor Day Surgery Department via the Main or Montgomery Elevator.

**Parking:** Parking is available opposite the Centre on William Sylvester Drive for \$10/daily maximum

**Food:** **Do Not** have solid foods or milk products after Midnight the night before surgery.

**Beverages:** You may have clear liquids up to three hours before admission to the facility.  
Clear fluids include water or apple juice only.

**Reminders:** Please bring your OHIP card to every visit.

Please bring a valid form of payment (visa,m/c,debit) if you are purchasing a premium lens.

Please wear loose comfortable clothing with a full button up front, as you will not be required to wear a hospital gown.

You will be discharged from the facility 20-45 minutes after surgery.

We recommend that you do not bring valuables to the facility or wear any eye makeup.

**If necessary, please arrange for a family member/friend to act as translator.**

**Please arrange for a support person or companion to accompany you home. Public transit (Wheel Trans only) can be used if you have a companion.**

**You will not be able to drive a car for 24 hours post surgery.**

**If you regularly take blood pressure or heart medication, please take as usual on the morning of surgery. If you are diabetic, do not take your oral insulin on the morning of surgery.**

A \$500.00 fee will apply for patients that cancel surgery with less than a one week notice. A \$100 fee will apply for patients who change their surgery date.
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## PATIENT INFORMATION FOR EYE SURGERY

### Welcome to Eye Surgery at North York General Hospital!

Due to the current COVID-19 pandemic, we anticipate community transmission for some time. A COVID-19 test is not required unless directed by your surgeon. Please note that the COVID-19 situation can change quickly, and your surgery may have to be cancelled at the last moment.

Patients and visitors will be screened for symptoms and hospital-supplied masks will be provided upon entrance. Visitors may be asked to wait within the building or outside of the unit. A staff member will contact them on their cell phone when it is time to return.

For the most up-to-date visitor policy, please visit our site: <https://nygh.on.ca/visitor>

Please arrive 1 hour before your surgery (or as directed by your surgeon's office).

While inside the building, please follow the safety measures in place to protect you:

- It is mandatory to keep your mask on at all times.
- Follow physical distancing of 2 meters (6 feet), this includes seating in waiting areas, elevators, and line-ups.
- No eating or drinking on site (e.g., in waiting areas)

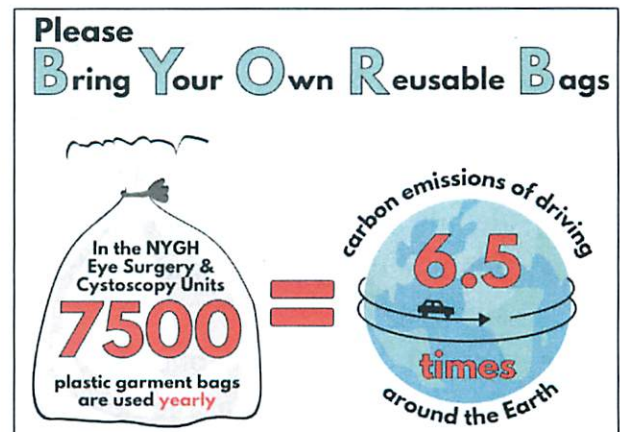
### Important Information

Please remember to bring your health card.

Please bring **one or two reusable bags** on the day of your surgery that are big enough to hold your personal belongings (i.e. grocery bag size).

**Do not** drive for 24 hours after your surgery.

- **Safe Ride Home:** You are required to have a support person provide you with a safe ride home. A support person can drive you home. **Public transit is not permitted after surgery.** When using



Wheels-Trans services your support person is expected to ride with you inside the Wheels-Trans vehicle to support you after surgery.

- **CANCELLED**- If you cannot organize a safe ride home with a support person, your surgery will be cancelled.

### **Instructions BEFORE Surgery**

If you develop a cough, cold, or fever within a week before your surgery, call your surgeon as soon as possible.

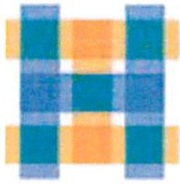
If these items listed below are not followed, your surgery may be delayed or cancelled:

- **Do not** eat anything (including gums, candy, or lozenges) after midnight the night before your surgery. You may brush your teeth.
- Blood pressure and heart medications should be taken on the morning of your surgery with a sip of water.
- Follow all the eye drop instructions provided by your ophthalmologist.
- **Do not** wear make-up.
- **Do not** wear scented products (e.g., perfume, cologne, body spray, lotions, and tobacco products).
- Wear comfortable clothing (preferably a shirt that buttons completely down the front).
- Please leave valuables at home. **NYGH is not responsible for personal items.**

### **Instructions AFTER Surgery**

Post-operative instructions will be provided upon discharge.

- Please review the 'A Safe Ride Home after Eye Surgery' infographic below for details about your ride home after your surgery.
- Light activity is allowed for the rest of the day. It is normal to feel a little dizzy or sleepy.
- **Do not** drink any alcoholic beverages for at least 24 hours after your procedure.
- Resume your regular medications as usual as well as all eye medications as directed by your surgeon and follow post-procedure orders.



## **PATIENT INFORMATION FOR DAY SURGERY**

### **A Safe Ride Home after Eye Surgery**



I cannot drive myself home after my surgery.



I cannot take public transit home from my surgery even with a support person (i.e. bus or subway).



I need an adult support person to accompany me on my ride home.



I need an adult support person to accompany me during my Wheel-Trans trip.



I need an adult support person to accompany me during my car, taxi, or Uber ride.



## PATIENT INFORMATION FOR DAY SURGERY

### A Safe Ride Home after Eye Surgery



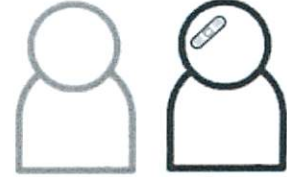
I cannot drive myself home after my surgery.



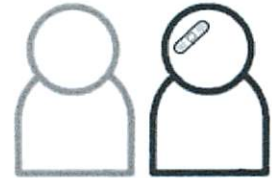
I cannot take public transit home from my surgery even with a support person (i.e. bus or subway).



I need an adult support person to accompany me on my ride home.



I need an adult support person to accompany me during my Wheel-Trans trip.



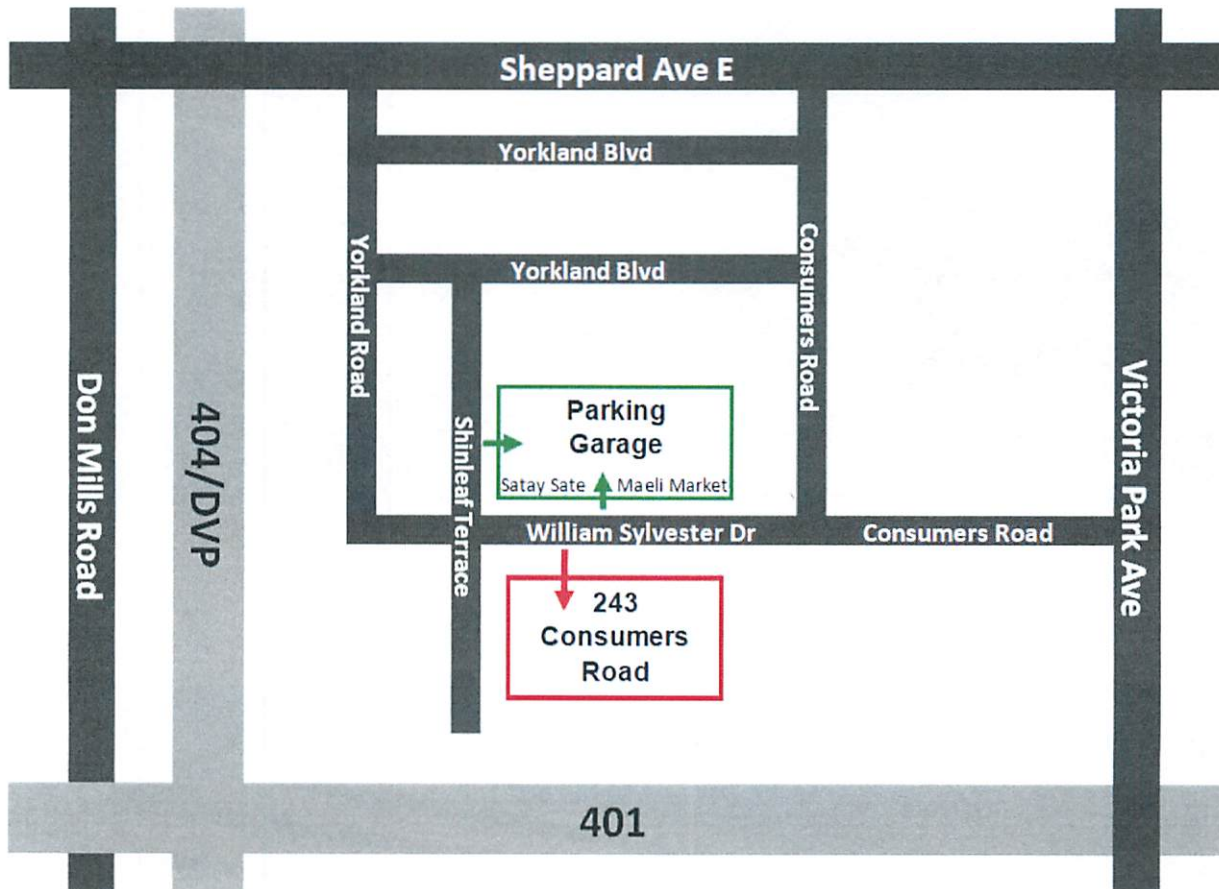
I need an adult support person to accompany me during my car, taxi, or Uber ride.





## LOCATION AND PARKING INFORMATION

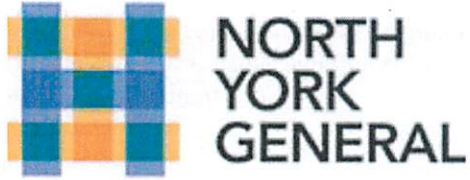
Welcome to Eye Surgery at North York General Hospital!



North York General Hospital – Eye Surgery  
 243 Consumers Road, 3<sup>rd</sup> Floor, Unit 300

Please note that the building is located on William Sylvester Drive.

Parking is available opposite the Centre on William Sylvester Drive for \$10/daily maximum by creditcard.



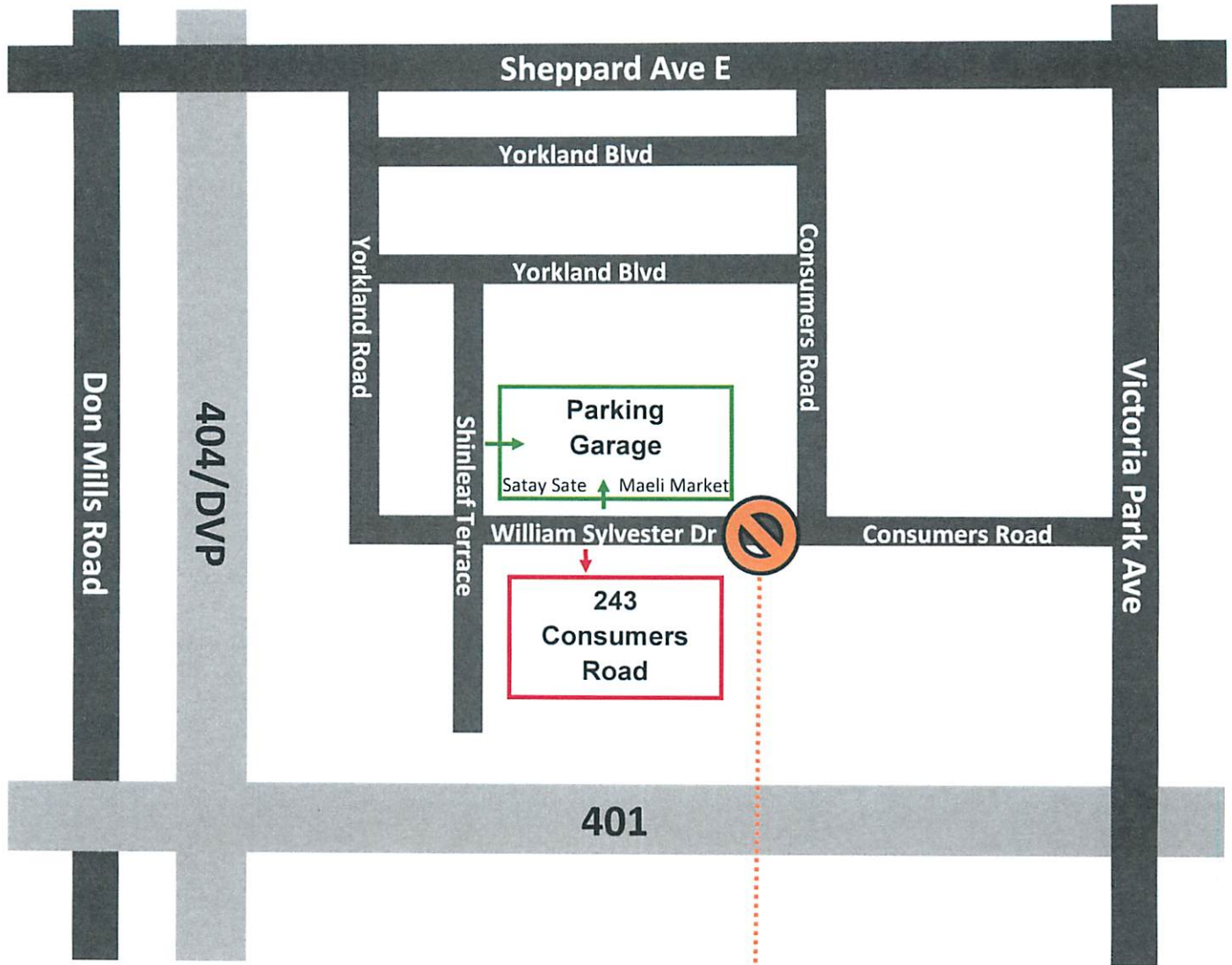
NYGH Minor Surgical Procedures and Elder Care Centre  
243 Consumers Road, 3<sup>rd</sup> Floor, Suite 300  
Toronto, ON M2J 4W8  
T. 416-756-6851  
F. 416-756-6414

### Entrance to 243 Consumers Road



### Entrance to Parking Garage





### **NOTE: Road Closure for Construction**

There is ongoing construction at the intersection for William Sylvester Drive and Consumers Road. With the road closure, 243 Consumers Road can be accessed via Yorkland Boulevard and Shinleaf Terrace.

The parking garage remains open.