Bermuda Hospitals Board

WARD _____

SURNAME..... MAIDEN NAME.....
FIRST NAME..... D.O.B.....
ADDRESS..... DOCTOR.....
CHART #.....
ICD Code.....

GENERAL CONSENT FORM

❑ KEMH ❑ MWI ❑ LF UCC ❑ Inpatient ❑ Outpatient

GENERAL CONSENT

I understand that I have the right to participate in decisions about my medical care. I have been informed of my rights and responsibilities when I receive services at Bermuda Hospitals Board facilities

I understand that care in Bermuda Hospitals Board (BHB) hospitals is provided by a multidisciplinary team of doctors, nurses, and other health care professionals. Understanding this team structure, I consent to be treated by the assigned members of the care team. I also authorize other health care professionals to carry out necessary examinations, assessments and/or treatments; these include but are not limited to: Physio and Occupational Therapists, Social Workers, Pharmacists, and Dietitians.

I authorize the hospital and the treating physicians, personnel or consultants involved in my care to have access to my medical records. I further authorize that information from my medical record may be given to physicians in hospitals outside Bermuda who may be consulted about my care and treatment. I understand that there is a separate policy governing the release of psychiatric medical records.

I authorize the health professionals involved in my care and the Bermuda Hospitals Board to release my medical information as needed to:

a. the insurance company or other reimbursement agencies in order to process this claim;

b. the Department of Health, other government departments, as may be required by law (for example the reporting of communicable diseases,) or to arrange for services I (or my dependent) may benefit from after discharge.

I authorize the hospital to send a summary of this hospitalization and any other release of medical information to my GP and/or referring doctor(s). I am aware that any additional request for the release of my medical record must be processed through the Health Information Management Service.

I understand that members of the health care team will verify my identity by asking my name and date of birth before a treatment or service. When required, the patient identification band placed on my wrist or ankle contains unique identifiers that hospital staff use in verifying that I receive the medications, investigations and treatments specifically ordered for me. I/my dependent have the responsibility to wear the patient identification band at all times. Should it come off, I must immediately inform a health care professional.

I understand that I should not bring valuables to the hospital, as the Bermuda Hospitals Board is not responsible for the loss, destruction or theft of personal property which includes but is not limited to: Glasses, dentures, hearing aids, electronic devices, jewelry and any other personal items.

I understand that I have the right to withdraw this consent at any time.

CONSENT FOR EXAMINATION OR TREATMENT

_____ _____

Signature of Patient/Legal Guardian | Date (dd/mmm/yyyy)

_____ _____

Name of Witness (PRINT NAME) | Signature of Witness

REFUSAL OF EXAMINATION OR TREATMENT

I refuse the following examination or treatment(s): _____

_____

This examination or treatment has been recommended by _____

I acknowledge that I have been informed of the risks or consequences, which can result from refusal of this examination or treatment, which has been recommended.

_____ _____

Signature of Patient/Legal Guardian | Date (dd/mmm/yyyy)

_____ _____

Name of Witness (PRINT NAME) | Signature of Witness

DEPARTURE WITHOUT AUTHORIZATION

I declare that I am leaving this hospital (with my dependent) and I am doing this of my own free will and initiative and against the advice of the treating physician(s). I have been advised of the possible risks and consequences.

_____ _____

Signature of Patient/Legal Guardian | Date (dd/mmm/yyyy)

_____ _____

Name of Witness (PRINT NAME) | Signature of Witness