Bermuda Hospitals Board

Quality and Risk Management

WARD ____________________

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

GENERAL CONSENT TO CARE FORM (GCC Form)

❑ KEMH ❑ MWI ❑ LF UCC ❑ Inpatient ❑ Outpatient

ACKNOWLEDGEMENT CONSENT AND AUTHORIZATION

I understand that I have the right to participate in decisions about my medical care.

I understand that as a patient, I am under the direct and indirect care of one or more licensed physicians on the medical staff of the hospital. I further understand that some of the physicians who provide treatment to me while I am here may not be employees of the hospital.

I understand that my overall care while in the Bermuda Hospitals Board (BHB) hospitals is provided by a multidisciplinary team of doctors, nurses, and other health care professionals including but not limited to Physiotherapy and Occupational Therapists, Social Workers, Pharmacists and Dietitians (together and individually known as the Care Team). I authorize the Care Team to carry out such examinations and assessments as are deemed by the Care Team to be in my best interests.

Understanding this team structure, I consent to be treated by the assigned members of the Care Team. This consent covers the following:

- All hospital services
- Diagnostic procedures such as Computed Tomography scan (CT) ***with or without contrast dyes***, Magnetic Resonance Imaging scans (MRI) ***with or without contrast dyes***, Plain X-Rays, Ultrasound scan, Electrocardiography (EKG) & Echocardiogram (ECHO)
- Laboratory procedures ***excluding blood product transfusions***
- Obtaining photographs, videotapes and / or recordings of me specifically for identification, diagnosis, treatment and internal healthcare operations
- Other procedures (***excluding surgical procedures***) that the Care Team in their entire discretion deem necessary or appropriate that do not require my specific informed consent.

BHB's use of my personal information

I understand that BHB will need to collect some or all of the following information about me in order to provide me with care, including for the procedures and uses set out above: physical and mental health or disability information; biometric information (such as facial images); genetic information (such as from a testing sample); my place of origin, race and colour; my sex, sexual orientation, sexual life, marital status and family status; and my religious beliefs.

I have been provided with access to BHB's Patient Privacy Notice which provides further details of BHB's use of this information and of my rights in relation to my personal information, or am aware that I can view an electronic copy at https://bermudahospitals.bm/or a physical copy at any Reception desk.

I authorize BHB and the Care Team to collect, access and use such information for the purpose of my care and for such information to be recorded in my medical records.

I also authorize BHB to disclose information regarding my care and treatment as needed to the following people (☑ as applicable):

- ❑ My chosen Next of Kin as identified during the intake process
- ❑ My immediate family (spouse/partner, parents, children)
- ❑ Other, please specify: ____

Release of Information

I further authorize BHB to release information from my medical records as needed to:

a) My General Practitioner (GP) and/or referring physician;

b) Physicians in hospitals outside Bermuda who may be required to be consulted about my care and treatment;

c) Insurance companies or other reimbursement agencies in order to process any claims in respect of my treatment; and

d) The Department of Health or other government departments or to arrange for services I (or my dependent) may benefit from after discharge.

I am aware that any additional request for the release of my medical record must be made to BHB's Health Information Management Service Department.

Identification

I understand that members of the 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 BHB staff use in verifying that I receive the medications, investigations and treatments specifically ordered for me. I understand that it is my responsibility to wear the patient identification band at all times. If I am signing this form on behalf of a patient, I understand that it is my responsibility to ensure that the patient wears the patient identification band at all times. Should it come off in either case, I understand that I must immediately inform a health care professional.

Personal Valuables

I understand that I should not bring valuables to the hospital, and that the BHB is not responsible for the loss, destruction or theft of any personal property, which includes but is not limited to - glasses, dentures, hearing aids, electronic devices, jewellery and any other personal items.

Revocation of Consent

a) I understand I have the right to revoke this consent any time, but acknowledge that doing so may prejudice BHB's ability to effectively provide me with care.

b) With respect to the consent granted specifically in relation to the use of photographs, videotapes and/or recordings, I understand that such consent can be revoked up until a reasonable time before such images/recordings are used.

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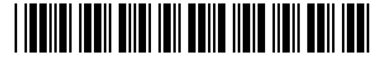

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My signature below certifies that I have read, understood and agree to abide by the terms set out in this General Consent to Care Form and that the information I have provided to the hospital is true, accurate and correct to the best of my knowledge including, without limitation, any information regarding financial assistance

____	____
Print Name of Patient/Legal Guardian/Authorised Representative	Signature of Patient/Legal Guardian/Authorised Representative
____	____
Name of Witness (Print Name)	Signature of Witness
____	
Date (DD/MMM/YYYY)	

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.

____	____
Print Name of Patient/Legal Guardian/Authorised Representative	Signature of Patient/Legal Guardian/Authorised Representative
____	____
Name of Witness (Print Name)	Signature of Witness
____	
Date (DD/MMM/YYYY)	

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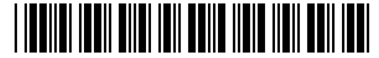

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DEPARTURE WITHOUT AUTHORIZATION

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.

_______________________________________	_______________________________________
Print Name of Patient/Legal Guardian/Authorised Representative	Signature of Patient/Legal Guardian/Authorised Representative
_______________________________________	_______________________________________
Name of Witness (Print Name)	Signature of Witness
_______________________________________	
Date (DD/MMM/YYYY)	