UNITY HEALTH TORONTO

Caring hearts. Leading minds.

I, _____ am travelling and will require treatment at the following dialysis clinic:

- ☐ St. Michael's Hospital Hemodialysis Unit, 30 Bond Street
- ☐ Kidney Care Centre, 45 Overlea Blvd.
- ☐ St. Joseph's Hospital Hemodialysis Unit, 30 The Queensway

☐ I have been informed and consent to my health information being sent to the designated dialysis clinic at Unity Health. Following a review of this clinical information, the Unity Health Physician and/or Nurse Practitioner will provide written treatment orders for my treatment at the dialysis clinic.

☐ I consent to receiving dialysis treatments at the clinic and understand that orders will be received for my treatment from a Unity Health Physician and/or Nurse Practitioner based on a review of my clinical history and current laboratory findings. There is a Unity Health Physician and/or Nurse Practitioner on call for any complication that may occur during my treatment. I understand the nature of the treatment, the expected benefits, material risks and material side effects of the treatment, alternative courses of action and the likely consequences of not proceeding with the treatment. Any questions I have about the treatment have been answered to my satisfaction.

☐ I understand that hemodialysis is a costly medical treatment and as such will compensate Unity Health in advance of each treatment, when payments are necessary, the full amount as outlined in the fee structure that has been provided to me.

☐ I acknowledge that I have read and understand the above consent and any other information regarding dialysis treatment at Unity Health, and agree to comply with the policies and procedures of Unity Health. I have had the opportunity to ask questions and have received answers to my satisfaction. I am aware that Interpretation Services and Accessibility supports are available to me, should I require assistance with understanding this document or any other information regarding dialysis treatment at Unity Health.

I understand/acknowledge that I have the right to refuse or withdraw consent at any time.

Patient/Substitute Decision Maker: _____

Name: _____ Date (y/m/d): _____

Unity Health Staff Signature: _____ Date (y/m/d): _____