ORILLIA SOLDIERS' MEMORIAL HOSPITAL

AUTHORIZATION
FOR
MEDICAL AND/OR SURGICAL TREATMENT

[redacted]

I, the undersigned/a parent of a patient in ORILLIA SOLDIERS' MEMORIAL HOSPITAL, ORILLIA, ONTARIO, hereby authorize Dr. [redacted], (and whomever he/she may designate as his/her assistants) to administer such treatment as is necessary, and to perform the

Oral examination, radiographs, dental cleaning (prophylaxis),
(name of operation)

and necessary restorations, extractions,

and such additional operation; or procedures as are considered therapeutically necessary on the basis of findings during the course of said operation.

I also consent to the administration of such anaesthetics as are necessary. Any tissues or parts surgically removed may be disposed by the hospital in accordance with legislation governing hospitals in this province and with accustomed practice.

I hereby certify that I have read and fully understand the above authorization for medical and/or surgical treatment, and am satisfied with the explanations made to me by Dr. [redacted] regarding, the need, advantages and possible complications of this operation. I also understand that no absolute guarantee or assurance can be made as to the results obtained.

Date: _____ Signed: _____
Patient

Time: _____ _____
(Spouse, Guardian, or Nearest Relative)

Witness: _____ Relationship to Patient _____

If Telephone Consent

Date: November 2, 1992

Time: 4:05 PM Mrs. [redacted]
(Name of person giving consent)

Witnesses: [redacted] CDA

[redacted] Mother
(Relationship to Patient)

[redacted]

CB [redacted]

Cottage 10

[redacted] C10

ORILLIA SOLDIERS' MEMORIAL HOSPITAL

AUTHORIZATION
FOR
MEDICAL AND/OR SURGICAL TREATMENT

I, the undersigned, (Guardian of) a patient in ORILLIA SOLDIERS' MEMORIAL HOSPITAL, ORILLIA, ONTARIO, hereby authorize Dr. [redacted], (and whomever he/she may designate as his/her assistants) to administer such treatment as is necessary, and to perform the

Oral examination, radiographs, dental cleaning
(name of operation)
(prophylaxis) and necessary, restorations, extractions.

and such additional operation; or procedures as are considered therapeutically necessary on the basis of findings during the course of said operation.

I also consent to the administration of such anaesthetics as are necessary. Any tissues or parts surgically removed may be disposed by the hospital in accordance with legislation governing hospitals in this province and with accustomed practice.

I hereby certify that I have ~~read~~ (HEARD) and fully understand the above authorization for medical and/or surgical treatment, and am satisfied with the explanations made to me by Dr. [redacted] regarding, the need, advantages and possible complications of this operation. I also understand that no absolute guarantee or assurance can be made as to the results obtained.

Date: _____ Signed: _____
Patient

Time: _____ _____
(Spouse, Guardian, or Nearest Relative)

Witness: _____ Relationship to Patient _____

If Telephone Consent

Date: FEB. 23 · 1994

Time: 01:00 MR & MRS [redacted]
(Name of person giving consent)

Witnesses: [redacted] RS

[redacted] CDA FATHER AND STEP - MOTHER
(Relationship to Patient)

[redacted]

ORILLIA SOLDIERS' MEMORIAL HOSPITAL

[redacted]

AUTHORIZATION
FOR
MEDICAL AND/OR SURGICAL TREATMENT

[redacted]

HURONIA REGIONAL CENTRE TELEPHONE CONSENT FOR DENTAL SURGERY

I, THE UNDERSIGNED, THE GUARDIAN OF [redacted]
WHO RESIDES AT HURONIA REGIONAL CENTRE/EDGAR, HEREBY AUTHORIZE DR. [redacted],(AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANTS) TO PERFORM: XRAYS, EXAM, CLEANING, PROPHY, EXTRACTIONS, RESTORATIONS

AND SUCH ADDITIONAL PROCEDURES AS ARE CONSIDERED THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SURGERY AT ORILLIA SOLDIERS' MEMORIAL HOSPITAL, ORILLIA, ONTARIO.

AS A GUARDIAN OF [redacted] I ALSO CONSENT TO THE ADMINISTRATION OF SUCH ANAESTHETICS AS ARE NECESSARY. ANY TISSUES OR PARTS SURGICALLY REMOVED MAY BE DISPOSED BY THE HOSPITAL IN ACCORDANCE WITH LEGISLATION GOVERNING HOSPITALS IN THIS PROVINCE AND WITH ACCUSTOMED PRACTICE.

I HEREBY CERTIFY THAT I HAVE HEARD AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT,
AND I AM SATISFIED WITH THE EXPLANATIONS MADE TO ME BY DR. [redacted] REGARDING THE NEED, ADVANTAGES AND POSSIBLE COMPLICATIONS OF THIS OPERATION. I ALSO UNDERSTAND THAT NO ABSOLUTE GUARANTEE OR ASSURANCE CAN BE MADE AS TO THE RESULTS OBTAINED.

DATE: 20/1/96
TIME: 10:37
RELATIONSHIP TO PATIENT: [redacted] SISTER

TELEPHONE CONSENT WITNESSES:

DENTIST: [redacted]
CDA: [redacted] CDA
DATE: [redacted]
TIME: 1/1/10:39