



Department of Families

Manitoba Developmental Centre
P.O. Box 1190
Portage la Prairie MB R1N 3C6
CANADA

Treatment Room Nurse or Outreach Nurse
Phone : (204)856-4279 or (204)856-4288
Fax : (204)856-4352

CONSENT FOR MEDICAL TREATMENT & PROCEDURES

- Surgical Procedure
- Medical Treatment
- Immunization
- Diagnostic Investigation
- Blood Products
- Other

RE: _____ DB: _____
Resident's Name Birthdate

I/We _____
Print name of SDM(s) for Personal Care or Resident's Name

Agree that Dr. _____ and/or his/her assistant may do the following:
Print Doctor's Name

1) The procedure has been explained in lay terms by Dr./Nurse. _____
Print Physician/Nurse's Name

2) I understand the purpose, nature, expected outcomes and potential complications of the proposed procedure, as well as the alternatives and consequences of not doing the proposed procedure.

Resident or Substitute Decision-Maker (SDM) Consent

Verbal/Telephone Consent (Witness required)

Resident or SDM Name and/or Signature & Relationship Date Time

Joint SDM Name and/or Signature & Relationship (if applicable) Date Time

Physician/Nurse Name and/or Signature Date Time

Witness Name and/or Signature & Relationship Date Time