Golden Care
MOBILE DENTAL SERVICES

2171 Avenue Road, Suite 205
Toronto, ON M5M 4B4
TF 1 877 221 4237
P 416 484 6228 F 416 484 6536

CONSENT TO TREATMENT

Name of Resident:

If the resident is incapable, Substitute Decision Maker (SDM):

Name of Facility /Room # :

SDM's Relationship to Resident:

* * *

This consent form relates to the provision of dental services by Golden Care Dental Services to the above named resident in a long-term care home, nursing home, retirement facility or private home (each, a "Facility").

1. Description of Treatment

For Patients with Natural Teeth: Oral Examination, X -Rays, Cleaning, Antimicrobial Treatment (Anti-Bacterial Wash) and Fluoride Treatment.

For Patients with No Natural Teeth (Dentures Only): Denture Examination, Cleaning and Labelling of Dentures.

2. Capacity with R espect to Treatment

The resident is able to understand the information that is relevant to making a decision about the treatment, and appreciates the consequences of a decision or lack of decision Yes ☐

OR

The resident is not capable of giving consent to treatment Yes ☐

3. I (SDM) will be present at each appointment Yes ☐ No ☐

Treatment can be provided in my absence Yes ☐ No ☐ Resident or SDM initials: _____

4. Consent to Treatment

I (the resident or SDM) hereby consent to have Golden Care Dental Services provide the dental services and treatment described in this consent to treatment form. I have had the opportunity to ask questions and have received satisfactory answers re garding any concerns I have with respect to the proposed treatment. I have had sufficient time to make an informed decision about the consent and understand that I may refuse to consent to the treatment and may revoke this consent at any time.

I (the resident or SDM) hereby consent to the release of (my or the resident's) medical information, personal health information and contact information to Golden Care Dental Services from (my or the resident's) Facility, healthcare practitioners, doctors and other health care providers as is required by Golden Care Dental Services.

_____
Signature of resident or SDM

_____
Witness signature (if signed by resident)

DATE OF CONSENT: _____

_____
Print name of witness