SHN
SCARBOROUGH HEALTH NETWORK

MENTAL HEALTH SERVICES
CONFIDENTIAL
INFORMED CONSENT FOR TREATMENT

847295

I understand that as a consumer of The Scarborough Health Network (SHN) Mental Health Program, I am eligible to receive a range of services. The type and extent of services that I receive will be determined following an initial assessment and discussion with me. I understand that SHN cannot always provide me with the services that will meet my needs. SHN will attempt to refer me to an appropriate alternative clinical service. However, I understand that it is ultimately my responsibility to seek the most appropriate treatment.

I understand that all information shared with the clinicians at SHN is confidential. During the course of treatment at SHN, it may be necessary for my therapist to communicate with other providers within the Mental Health Program at SHN. It is also understood that SHN staff may communicate with my family doctor and or/ other referring sources. In all other circumstances, consent to release information is given through written authorization. I further understand that there are specific and limited exceptions to this confidentiality which include the following legal responsibilities:

A. When there is a risk of danger to me or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. Where there is suspicion that a child is being sexually or physically abused or is at risk of such abuse.
C. When a valid court order is issued for medical records.
D. When there is a cognitive impairment that may affect driving ability.

I understand that there may be other exception to confidentiality as described under the Personal Health Information Protection Act (PHIPA), 2004 and that I am responsible to review this information.

A hospital brochure answering frequently asked questions about PHIPA is available upon request.

Complaints re: confidentiality can be directed to the Manager of Compliance and Risk

Management of SHN at (416) 438-2911 ext 6690

I understand that a range of mental health professionals, some of whom are in training, provide SHN services. SHN will inform me when such people are involved.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that SHN Mental Health Services offer its services for the assessment and treatment of my health issues and not specifically for the purposes of legal issues, and insurance or disability purposes.

I understand that in order to ensure my safety I must bring 2 forms of identification to each visit. If possible, one with a photo identification. In some cases, SHN may ask me to be photographed in order to properly identify me for purposes of service delivery.

I understand that SHN Mental Health Services has a zero tolerance policy regarding both verbal and physical violence and I may be refused service should any staff feel threatened in any respect.

I understand that I must give at least 48 hours notice of cancellation. If I miss 2 appointments without such notification I understand that my file may be closed at the discretion of SHN Mental Health Services.

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I understand that I have the right to terminate treatment at any time. Should I have any concerns regarding my treatment I understand that I can:

1) First speak to my therapist.
2) If unresolved speak to the appropriate program manager.
3) If still unresolved speak to the Patient Care Director.

I have read and understand the above. I consent to participate in the treatment by SHN Mental Health Out-Patient Services.

Print Patient/Designate Name ABISHEKH MANOHARAN Patient/Designate Signature _____ Date 25/05/2023 (dd/mm/yyyy)

Physician/Nurse/Allied Professional

Print Name _____ Signature _____ Date _____ (dd/mm/yyyy)

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