

Privacy Policy & Information

Midwifery Services of Durham & Markham Stouffville Midwives

Commitment to Privacy

The appropriate collection use and disclosure of clients' personal health information is fundamental to our day-to-day operations and to patient care. You may view your records or our privacy policy at any time. Our privacy officer is Patricia Patry, RM.

Protecting the privacy and the confidentiality of client personal information is important to the midwives and staff at Midwifery Services of Durham & Markham Stouffville Midwives.

We strive to provide our clients with excellent medical care and service. Every member of Midwifery Services of Durham & Markham Stouffville Midwives must abide by our commitment to privacy in the handling of personal information.

Identifying Purposes: Why We Collect Information

Midwifery Services of Durham & Markham Stouffville Midwives uses your personal information to facilitate your treatment and to ensure that you are receiving quality care. We will use and disclose your information for the following purposes:

- To ensure continuity of care between healthcare providers operating within Midwifery Services of Durham & Markham Stouffville Midwives.
- To allow us to communicate with you regarding the booking of appointments, follow-up visits and payment of bills
- For teaching purposes on an anonymous basis
- To send progress notes to your physician
- To send the appropriate referrals for consultations to Obstetricians, Anesthetic, Hospitalist Midwives at Markham Stouffville Hospital, Pediatricians or other health specialists that may need to be involved in your care.
- To comply with legal regulatory standards of individual health care providers
- To invoice for services (from our Transfer Payment Agency, Markham Stouffville Hospital)

Access to personal Information

Your personal information will not be released to anyone else without your consent, **including your partner**. In certain conditions, you may want us to communicate with other persons (i.e. booking/confirmation of appointments). We require your authorization in order to disclose this information. Please indicate below to whom we may communicate with. ***Please know that you can withdraw your consent to share personal information to the individual below at any point.***

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Client/Patient Name: _____ Client Signature: _____

Date: _____

Client Consent to Release Personal Information

To:	Midwifery Services of Durham & Markham Stouffville Midwives	(the "Practice Group")
And To:	Markham Stouffville Hospital	(the "Transfer Payment Agency")
And To:	The Ministry of Health and Long-Term Care	(the "Ministry")

In order to enable the Transfer Payment Agency and the Ministry to:

1. Verify the services the Practice Group has provided to me; and
2. Administer, monitor and evaluate the Midwifery Program in Ontario,

I agree to allow the Practice Group to provide, at any time during or after my Midwifery care, the following information to the Transfer Payment Agency and to the Ministry:

1. My health card number (if I have one)
2. My Name
3. My address and postal code
4. My birthdate
5. My booking date, due date and discharge date
6. The number of visits with the Practice Group
7. The Dates of my visits with the Practice Group
8. The clinical services I (or my infant) receive from the Practice Group and the clinical outcomes and location of those services
9. Whether the Practice Group referred me to a physician for any services during my Midwifery Care
10. The Number and kind of services I received from the physician as a result of the referral by the Practice Group; and
11. My infant's health card number, if i receive one

I acknowledge that the Practice Group has explained the content and purpose of this consent for me and that I have had my questions answered to my satisfaction. I Understand that the Transfer Payment Agency or the Ministry may contact me for further information, if necessary.

Name: _____

Client Signature: _____ Date: _____

Ontario Midwifery Program

Client Consent

MARKHAM STOUFFVILLE HOSPITAL

Markham Site Uxbridge Site

ANAESTHESIA

PATIENT QUESTIONNAIRE

Name:

Date of Birth:

Health card #:

Date

1. List all your previous Surgeries I have had no Surgeries

Procedure	Hospital	Year

- | | | |
|--|---|-------------------|
| 2. Have you or any family members (including aunts, uncles & cousins) had an adverse reaction to anaesthetic drugs? e.g. malignant hyperthermia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Don't Know |
| 3. Have you ever had heart problems? (if yes, please check which one) Heart Attack, Angina, Rheumatic Fever, Heart Murmur, Rhythm problems, Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 4. Have you ever had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 5. Have you had chest or breathing problems? (if yes, please check which one) Asthma Emphysema, Bronchitis, Tuberculosis, Pneumonia, Sleep Apnea, Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 6. Have you had an injury or do you have a condition affecting your neck or jaw? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7. Have you had Hepatitis A, B or C? (if yes, please specify): | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. Have you had or do you have diabetes? (if yes, please check) Diet Controlled Oral Medication Insulin Dependent | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 9. Do you have or have you had kidney problems, stroke, epilepsy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10. Have you had a blood transfusion in the last 3 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. Do you have bleeding problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. Do you have false teeth, caps, crowns, loose teeth, contact lenses, hearing aid? (if yes, please check off which ones) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 13. Do you smoke? (if yes, amount per week) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 14. Do you drink alcohol? (if yes, amount per week) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 15. Do you have a history of complications during pregnancy? e.g. toxemia | <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 16. Have you taken steroids in the last 6 months? (not including Cortisone Injections) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 17. Are you allergic to anything (medications, latex, food, environmental, other)? (if yes, please list) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

18. List current regular medications you are taking, including over-the-counter drugs.

19. List serious illnesses you have had in your life and the approximate year.





381 Church Street
P.O.Box 1800
Markham, Ontario L3P 7P3

Markham Site

Uxbridge Site

OBSTETRICAL CONSENT TO TREATMENT

Name of Patient: _____

1. I consent to those treatments/procedures/operations deemed necessary which reflect responsible management of my pregnancy/labour/birth/postpartum care. The consent includes the routine and emergency care of my newborn baby/babies.
2. I further agree that the practitioner below may assign other surgeons, physicians, midwives and hospital staff to perform all or part of the investigation, treatment or operative procedures. I also agree that they shall have the same discretion in my investigation and treatment.
3. I understand that Markham Stouffville Hospital has teaching commitments and various healthcare personnel may be involved in my care during the Hospital stay.
4. If it is determined to be medically advisable during the course of my treatments/procedures/operations, I give my consent to the administration of anaesthetics/pain medication including, but not limited to local, regional (e.g., epidural) or general anaesthetic.
5. I request and expect that in a situation where additional procedures may be deemed necessary, (e.g. a Caesarean section, forceps birth, vacuum birth) every opportunity will be taken to explain the circumstances to me and my support person insofar as time and safety permits.
6. In compliance with provincial legislation, I acknowledge that the hospital may utilize tissue specimens removed during my procedures for research and/or teaching purposes.
7. The possibility of the administration of blood or blood products including Rho(D)Immune Globulin (RhIG) has been fully discussed with me, and a consent or refusal form for blood or blood products has been completed as per this discussion.
8. I confirm that I have had ample opportunity to raise questions concerning the expected benefits and material side effects of treatment/procedures/operation involved in the management of my pregnancy/labour/birth/postpartum care and the routine care of my newborn baby/babies. I confirm that I understand, accept and am satisfied with the explanations provided.

Signature of Patient
(or Substitute Decision Maker, if applicable)

Name of Substitute Decision Maker, if applicable

Signature of Physician/Midwife

Date



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Markham Site

Uxbridge Site

CONSENT FOR TRANSFUSION OF BLOOD AND/OR BLOOD PRODUCTS

1. I have been informed that during my treatment, it may be necessary to receive a transfusion of blood and/or blood products. I understand what a transfusion is and the procedure that will be used.
2. I have been given written educational material about the risks and benefits of blood products and have had the opportunity to discuss any questions and concerns with my health care provider.
3. I understand that the Canadian Blood Services (CBS) has taken the accepted precautions in selecting blood donors and in collecting, testing and storing blood and blood products for transfusion. I understand that Markham Stouffville Hospital and its staff have taken the accepted precautions in storing and preparing the product(s) for transfusion.
4. I have been told about the risks of receiving a transfusion from volunteer donors. I understand that no absolute guarantees can be or have been given to me concerning the potential risks associated with the transfusion of blood and/or blood products. I understand that risks exist even though the blood has been tested and may even be my own.
5. In some cases, my own blood (autologous) may be used for transfusion. I have been made aware that there are risks even with donating or receiving my own blood and I have discussed this with my doctor. I have been told that even if my own blood is used, it may be necessary to give me additional blood or blood products donated by others.

The treatment and transfusion procedure has been fully explained to me. By signing below I accept that I understand the associated risks and benefits and that I have had an opportunity to ask and have my questions answered.



Signature of Patient

OR

Signature of Substitute Decision Maker

PRINT Patient Name

PRINT Substitute Decision Maker Name/Relationship

Date

Date

Physician Statement:

I have explained the nature of the treatment, its associated risks, benefits, possible alternatives, as well as the likely consequences of not having treatment. I have provided the appropriate written information and have answered any request for additional information by the patient or Substitute Decision Maker.

Physician/Surgeon Signature _____

Date _____

PRINT Physician/Surgeon Name _____