CONSENT

❖ Care and treatment monitoring of a HCV patient+ ❖

1. I, the undersigned, _____ acknowledge receiving all the necessary information prior to signing this form, which states that I accept to receive strict monitoring for treating my hepatitis jointly **by the HCV team of the Timiskaming First Nation Health Center, comprised of a trained nurse and social worker and by the Val d'Or hepatology clinic of the CISSS de l'Abitibi–Témiscamingue comprised of a nurse and a gastroenterologist** for the sole purpose of receiving optimal care.

2. I understand that the results of examinations and blood work that are carried out regularly at the Health Center of my community will be sent **directly to the medical team at the Val d'Or hepatology clinic** of the **CISSS de l'Abitibi–Témiscamingue** so that a medical specialist can interpret the medical data and adequately follow the progression of my health condition.

3. I understand that **a nurse from the Health Center of my community will contact me if abnormalities are detected so that I can be referred to the proper follow-up by the Val d'Or hepatology team of the CISSS de l'Abitibi –Témiscamingue.**

4. I understand that I am consenting to follow medical recommendations and to accept care as well as monitoring which is adapted to my health condition during the period prescribed by the gastroenterologist. I intend to attend all my appointments and follow the treatment plan.

4. I understand that my personal data will be kept confidential, and in order to receive optimal care, will be kept in 2 separate files : at the Timiskaming First Nation Health Center and at the Val d'Or hepatology clinic of the **CISSS de l'Abitibi –Témiscamingue** :

(a) The health care staff, doctors and nurses of the **Val d'Or hepatology medical clinic of the CISSS de l'Abitibi-Témiscamingue;**

(b) The health care staff of the **HCV medical team at the TFN Health Center** ;

(c) The doctor(s) I have identified during my initial visit with the gastroenterologist ;

(d) Any other professional with my written consent.

CONSENT

I therefore agree to abide by the treatment plan and recommended medical monitoring.

Client

Name :
(*Print*) _____ _____
The patient or legal representative — Relationship (*if applicable*)

Signature : _____ Date : _____

Witness

Name :
(*Print*) _____

Signature : _____ Date : _____