ST JOSEPH'S HEALTH CARE LONDON

E-MAIL COMMUNICATIONS WITH PATIENT AGREEMENT

Email: _____

I _____,
NAME IN FULL OF PATIENT OR SUBSTITUTE DECISION MAKER

the _____ of _____
RELATIONSHIP TO PATIENT, IF SUBSTITUTE DECISION MAKER — NAME OF PATIENT

have discussed communicating with, DEC Staff (Including educators & clerical) via e-mail.
NAME OF HEALTH CARE PROVIDER

I acknowledge and agree that:

- E-mail is not a secure or confidential form of communication. As the message leaves St. Joseph's Health Care (SJHC), it is sent across the Internet, where it could be intercepted and read. For this reason, SJHC cannot guarantee the security of messages that are sent to and by me
- My care provider will not use e-mail to communicate sensitive personal or health information
- Specific issues that will **not** be discussed via e-mail include:

  _____
- E-mail will **not** be used to communicate emergency or urgent health matters, as I understand that:
  - e-mail messages can be delayed for both technical reasons and issues relating to the availability of the health practitioner and
  - my condition or the emergency situation cannot be adequately assessed via e-mail
- Clinical decisions about treatment or care may be made on the basis of health information conveyed in e-mail messages
- A printout of any e-mail communication related to treatment or care will be stored in my/the patient's hospital record
- Either party may stop communication via e-mail at any time if the conditions in this agreement are not adhered to. Notice must be given in writing to the patient/SDM or health care provider as applicable, if this form of communication is to stop.

E-mail **may** be used for:

- Conveying routine test results
- Scheduling appointments
- Certain counseling, e.g. nutritional
- Other reasons as agreed upon by myself and my health care provider: _____

  _____

Date:_____ _____
(YYYY/MM/DD) — SIGNATURE OF PATIENT OR SUBSTITUTE DECISION PROVIDER

_____
PRINTED NAME OF PATIENT OR SUBSTITUTE DECISION PROVIDER

Date:_____ _____
(YYYY/MM/DD) — SIGNATURE OF HEALTH CARE PROVIDER

_____
PRINTED NAME OF HEALTH CARE PROVIDER

Other individuals to receive and send e-mail on behalf of the health care provider to be indicated on back of form.

COMPLETED FORM TO BE PLACED ON THE PATIENT'S HOSPITAL RECORD

Other individuals to receive and send e-mail on behalf of health care provider:

Date: _____ (YYYY/MM/DD) _____ PRINTED NAME OF INDIVIDUAL

_____ SIGNATURE OF INDIVIDUAL

Date: _____ (YYYY/MM/DD) _____ PRINTED NAME OF INDIVIDUAL

_____ SIGNATURE OF INDIVIDUAL

Date: _____ (YYYY/MM/DD) _____ PRINTED NAME OF INDIVIDUAL

_____ SIGNATURE OF INDIVIDUAL

Date: _____ (YYYY/MM/DD) _____ PRINTED NAME OF INDIVIDUAL

_____ SIGNATURE OF INDIVIDUAL

TELEPHONE CONSENT

I _____ have spoken with,
PRINTED NAME OF HEALTH CARE PROVIDER OBTAINING INFORMED CONSENT

_____ by telephone as that person
NAME OF PATIENT OR SUBSTITUTE DECISION MAKER

is not available to attend at the hospital to sign the written consent form and communication of the consent form by facsimile or other electronic transmission is not reasonably available. I have obtained informed consent over the telephone for e-mail communication with, _____ .
NAME OF PATIENT OR SUBSTITUTE DECISION MAKER

Date and Time of Telephone Call:

_____ (YYYY/MM/DD) _____ (HH:MM) _____ SIGNATURE OF HEALTH CARE PRACTITIONER

_____ SIGNATURE _____ PRINTED NAME
OF HEALTH PRACTITIONER WHO HAS WITNESSED THE FULL CONVERSATION WITH RESPECT TO INFORMED CONSENT