Hamilton Health Sciences
PATIENT EDUCATION

Michael G. DeGroote PAIN CLINIC

Consent to treatment

You are to receive services from the Interdisciplinary Group Program. This Program is part of the Michael G. DeGroote Pain Clinic, Hamilton Health Sciences.

This handout provides information that is important for you to know and understand. To begin with the Program and treatment, we need your informed consent. Please read carefully and ask us to explain anything that you do not understand. You have the right to withdraw consent or your involvement in the Program at any time.

1. Your pain condition

- It has been explained to me, and I understand, that I suffer from a form of chronic pain.
- This means that my pain lasts longer than the usual healing process.
- My pain has not been successfully treated using other treatments and services that have been provided.

2. Length and nature of Chronic Pain Program

- I understand that there are different types of health care providers who will provide services. This is called an Interdisciplinary Team which include:
  - Doctors
  - Occupational Therapists
  - Pharmacists
  - Physiotherapist
  - Psychologist
  - Psychometrist
  - Social Worker
- This Program is specific to chronic pain and may last up to 4 weeks.

- I understand that there are daily group sessions. These groups are about learning skills to help me manage my pain more effectively in the long term.
- I will be participating in group and individual sessions to learn new pain management skills in a number of areas. These areas include: fitness, nutrition, functional activities and how to handle emotional distress.
- I will be participating in daily fitness and exercise, including the use of a pool. The fitness component is an essential part of the Program. Through exercise you will become aware of how you can challenge your nervous system to build physical strength, endurance and improve your confidence.
- I will be expected to set goals in a number of areas on a regular basis. These areas include: social and family life, productivity (such as work, school, chores, yard work), recreation, medication, nutrition, emotional, general health and fitness.
- I will meet with my case manager on a regular basis. During this meeting we will discuss my goals, progress in the Program and specific areas of difficulty.
- I may also involve family members in discussions with Program staff.

3. Risks and benefits of the Program

- I understand that people who complete an Interdisciplinary Pain Program are more likely to:
    - Improve their participation in activities
    - Experience less emotional distress
    - Reduce their need for medical treatments
    - Improve their overall quality of life
    - Return to productivity such as work, school, chores, yard
- I understand that my pain will not necessarily get better during my stay in the Program. As well, I may experience pain or discomfort during my efforts to improve my tolerance and coping skills.
- I understand that increased physical activity carries with it a certain risk of strain or accident. I will work closely with Program staff to follow safe practices in order to avoid the risk of unnecessary accidents or injuries.
- I may be doing some physical and functional activities using equipment. I will assume the responsibility to follow safe practices and follow the Programs rules about the use of such equipment.

- Instead of coming to the Program, I understand that different treatments involve obtaining services from my doctor or other health care provider for my pain condition. However, I understand that a less intensive treatment Program may result in less effective long-term lifestyle changes as those encouraged through this Program.
- I am aware that I may be asked to leave the Program by the staff if one or more of these occur:
  - I repeatedly fail to keep appointments
  - I am not actively participating or appear not to be engaged in the Program
  - I show evidence of aggressive or disrespectful behaviour
  - I show evidence of drug (legal or illegal) or alcohol intoxication
  - I smoke anywhere on hospital grounds or use illegal drugs anywhere on hospital grounds

4. Confidentiality

- I understand that my personal health information will be collected, used and shared among Program staff and health care providers who assist in providing my health care.
- I understand that my personal health information will be protected and will only be shared with parties outside the Program (such as insurers) in cases where I have been given my expressed consent.
- I am aware that I can let Program staff know if I do not want them to collect, use or share my personal health with others. I am aware that certain risks may be involved in withholding this information from outside sources (such as insurers).
- Any records relating to me will be kept confidential. No information will be released or printed that would disclose my personal identity without my awareness and consent.
- I am aware that there are a few legal exceptions to these confidentiality rules if I:
  - am judged to be at risk of harming others or myself
  - disclose inappropriate sexual behaviour on the part of another health professional
  - the court subpoenas my records
  - a child is at risk of being abused or neglected

- I understand that I must keep any information revealed during group sessions by other Program members completely confidential.
- If I have any questions about the Program's privacy practices, I am aware that I can consult posted privacy materials and / or speak with my case manager or any other Program staff.

5. Teaching and Research

- I understand that the Michael G. DeGroote Pain Clinic is part of a teaching hospital. There are many learners and health care professional students who provide treatment and work at the hospital. All learners are supervised by licensed experienced staff.

  As part of the ongoing process to assess and improve our Program, I will be asked to complete several surveys that are used for clinical purposes. The results are put into a report. As well, the information collected may be used for research purposes and presented to the scientific community, in professional journals or at professional conferences. Confidentiality is kept. No names are used when data is analyzed and presented.

I have read and understand points 1 to 5 above. My questions have been answered to my satisfaction. By signing this consent form, I understand and agree to the terms and conditions stated above.

______________________	______________________
Name (printed)	Witness
______________________	______________________
Signature	Date

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