Informed Consent for Participation in the "Memory Care Program"

This "Informed Consent" document is for Patients/Residents at Name of Medical Clinic/ Retirement/LTC Home**.**

It has two parts:

- **Information Sheet (to share information about the program with you)**
- **Certificate of Consent (to be signed if you are willing to participate in this program)**

PART I: Information Sheet

Introduction

Name of Lead Physician/Geriatrician, in collaboration with the Healthcare staff at Name of Medical Clinic/Retirement/LTC Home and Pharmacy Provider name, have designed a program to make sustainable changes to improve dementia care.

Purpose of the Program

Every 4 minutes in Canada, someone is diagnosed with Dementia. It is our country's largest cause of disability and debilitation. As you age, your risk of Dementia increases significantly. However, research has shown that early diagnosis, treatment and management of the disease can significantly improve the lives of those at risk. The "Memory Care Program" at Name of Medical Clinic/Retirement/LTC Home is designed to focus on these areas in order to make significant improvements to the memory care of its Patients/Residents.

Participant Selection and Participation

All Patients/Residents who **do not** have a current diagnosis of Dementia/Alzheimers are invited to participate. Participation is completely voluntary and if you choose to do so, you can withdraw at any time.

Process

Participants in this project will receive:

* A two minute Memory Screen given by a staff member (involving animal naming, 3 word recall, and clock drawing) as well as a Memory Risk Calculation based on age and vascular risk factors.

* If your screening results are normal, you can be reassured that your brain function is good. If there is any identified concern with the screening, staff will conduct a more comprehensive assessment.

*Name of Pharmacy Provider will also be conducting Medication Reviews to identify and resolve common medication related issues. Since some medications can cause changes in cognition (memory and thinking), these reviews will ensure that the Patient/Resident gains the most benefit from their medication while eliminating potential side effects and minimizing risk.

* All of this information will be passed to the Patient/Resident's Physician and decisions on any potential diagnosis or potential treatment will be made between the Physician and the Patient/Resident and/or family member(s).

Confidentiality
All individual information about a Patient/Resident in this program will be kept confidential. There will be no names used in any information shared among program team members. To ensure this, each Patient/Resident will be identified by a number.

PART II: Certificate of Consent

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I have read this information, or it has been read to me and I have had the opportunity to ask questions and these questions have been answered to my satisfaction. I consent voluntarily to participate as a participant in this program.

Print Name of Participant_____

Signature of Participant _____

Date _____
Day/month/year

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____

Signature of witness _____

Date _____
Day/month/year

A copy of this Informed Consent Form has been provided to the participant.

Print Name of person taking the consent_____

Signature of person taking the consent_____

Date _____
Day/month/year

William B. Dalziel, MD, FRCPC, Professor of Geriatric Medicine, University of Ottawa;
Regional Geriatric Program of Eastern Ontario