



Form C: Adults without the capacity to consent to treatment

<p>Affix hospital identification here</p> <p>Adults without the capacity to consent to treatment</p> <p>If using this form, the patient has been deemed to not have capacity to make this decision.</p>	<p>Affix patient identification label here</p>
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Proposed treatment/procedure/investigation

List the treatment(s)/procedure(s)/investigation(s) to be performed (referred to as "Treatment" in this form), noting correct location of the Treatment (no abbreviations):

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This procedure requires:

Local anaesthesia Insertion of implantable medical device General and/or regional anaesthesia

An anaesthetist will explain the risks of general or regional anaesthesia.

Reason for the adult being incapable of consent

The patient is incapable of consenting to the Treatment because they: (Tick one of the boxes below)

are unconscious

have diminished consciousness (i.e. related to medication or other drug use or extreme pain)

are cognitively impaired

Provision of written information

The following information sheet/s have been provided to the substitute decision maker:

Procedure Specific Information Sheet (PSIS) No PSIS available Other (please specify):

.....

Risks and complications

Risks and benefits discussed with the substitute decision maker include:

If blood and blood product transfusion/infusions are anticipated, refer to the 'Consent to Blood and Blood Products' form (Form E). If consent for blood and blood products is declined, please refer to your 'Refusal of Blood Products' form.

Signature of doctor/health practitioner who has determined consent has been obtained

Risks and benefits of the treatment have been discussed with the patient and relevant consent discussions are documented within this form and within the patient's medical record should additional space be required.

Doctor/Health practitioner's full name (print)

Position/title

Doctor/Health practitioner's signature Date Time

Second signature of doctor/health practitioner who has determined consent has been obtained (if applicable)

Risks and benefits of the treatment have been discussed with the patient and relevant consent discussions are documented within this form and within the patient's medical record should additional space be required.

Doctor/Health practitioner's signature Date Time

Declaration of substitute decision maker

1. I have been given written information about the Treatment (if available).
2. I understand that the doctor/health practitioner who discusses the Treatment with me for the purpose of consent may be different to the doctor/health practitioner who performs the Treatment.
3. I have been informed of and understand the risks that are specific to the patient, benefits, the alternatives (including if I choose to decline the Treatment on behalf of the patient) and the likely outcomes.
4. I have been given the opportunity to ask questions about the Treatment and my specific queries and concerns have been answered.
5. I understand that if immediate life-threatening events happen during the procedure, the patient will be treated accordingly.
6. **I consent to a blood product transfusion** YES NO (please tick). The risks and benefits that are specific to the patient have been explained to me and I have received written information.
7. If a staff member is exposed to the patient's blood, I consent to the patient's blood being collected and tested for infectious diseases. I will be informed if this occurs and will be given results of the tests.
8. I consent to an examination by a health practitioner student if assigned to the patient, supervised by a doctor/health practitioner while the patient is anaesthetised YES NO N/A (please tick).
9. I consent to de-identified medical photography and video of the patient for the purposes of medical research and training.
10. I understand that I have the right to change my mind and can withdraw my consent to Treatment at any time before the Treatment is performed, including after I have signed this form. I understand that I must inform the doctor/health practitioner if this occurs.
11. I give consent for the patient to undergo the Treatment as documented on this form.

Signature of substitute decision maker

Full name of substitute decision maker (1)

Relationship to patient

Substitute decision maker's signature Date Time

Authority (*Guardianship and Administration Act 1990* – state the relevant category as per the hierarchy of decision)

Full name of substitute decision maker (2)

Relationship to patient

Substitute decision maker's signature Date Time

Authority (*Guardianship and Administration Act 1990* – state the relevant category as per the hierarchy of decision)

Interpreter's declaration (if applicable)

Specific language services required

I declare that I have interpreted the dialogue between the substitute decision maker and doctor/health practitioner to the best of my ability and have advised the doctor/health practitioner of any concerns about my interpreting of this dialogue.

Interpreter's full name (print)

Agency name NAATI number

Interpreter's signature Date Time

Interpreting took place: in person or via phone/videoconference

Review of consent (if applicable)

I confirm that the patient's consent, and clinical condition have been reviewed and the Treatment is still appropriate to be undertaken.

Doctor/Health practitioner's full name (print)

Position/title

Doctor/Health practitioner's signature Date Time

I confirm that the request and consent for the Treatment above remains current and I am still authorised to make a decision about treatment for this patient. I am satisfied that I have enough information to make this decision.

Substitute decision maker's signature Date Time

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