

Substitute Consent Form Amendment - Patient Information & Consent to Medical Treatment PD2005_406

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Functional Sub group Clinical/ Patient Services - Medical Treatment
Clinical/ Patient Services - Records

Summary The substitute consent form previously issued with the Consent Policy requires minor corrections. PD2005_406 amended.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals

Audience All staff

Distributed to Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes

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AMENDMENT TO SUBSTITUTE CONSENT FORM ANNEXED TO THE PATIENT INFORMATION AND CONSENT TO MEDICAL TREATMENT POLICY DIRECTIVE 2005_406

Policy Directive “Patient Information and Consent to Medical Treatment” (PD2005_406) annexes three model consent forms that are to be used in public health organisations.

Minor errors were identified in the substitute consent form in the acknowledgement of advice section and have been corrected. A copy of the corrected substitute consent form is annexed to this Information Bulletin.

The version of the form attached to the Policy Directive has also been amended.

Robyn Kruk
Director-General

SUBSTITUTE CONSENT FOR MEDICAL TREATMENT

GUARDIANSHIP ACT 1987

(For patients 16 years and above where consent is provided by a person responsible)

TITLE	FAMILY NAME	MRN		
GIVEN NAME/S		VMO		
ADDRESS	STREET	DOB	SEX	HIS
SUBURB		POSTCODE	ADMISSION DATE	

Medical Advice

To be completed by Medical Practitioner

I, Dr confirm that is
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF PATIENT

incapable of consenting to medical treatment because:

- (Tick one) he/she cannot understand the nature and effect of the treatment
 or he/she cannot indicate whether or not he/she consents

The patient's condition that requires treatment is

Significant risks in not treating are

The site of the proposed procedure or treatment and its general nature and effect are

DO NOT USE ABBREVIATIONS

The proposed procedure/treatment has the following significant risks and/or side effects

Reasonable alternatives (if any) to the proposed procedure/treatment and significant risks and/or side effects associated are

The proposed treatment is the most appropriate form of treatment to promote the patient's health and well-being.

.....and I have discussed the patient's present condition and
NAME OF PERSON RESPONSIBLE

I have also explained:

- that other forms of treatment, such as anaesthetics, medicines, or blood transfusions, may be associated with the procedure/treatment and that these may carry some risks;
- that other unexpected procedures or treatments are sometimes necessary;
- that complications may occur or the expected result may not be achieved even though the procedure/treatment is carried out with due professional care.

...../...../20..... /...../20.....
SIGNATURE OF PERSON RESPONSIBLE DATE SIGNATURE OF MEDICAL PRACTITIONER DATE

Interpreter present */...../20.....
SIGNATURE OF INTERPRETER DATE

Acknowledgement of advice

To be completed by the person responsible/guardian

Dr and I have discussed
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF PATIENT's

present condition and the various ways in which it might be treated as above. The doctor has told me that:

- The procedure/treatment carries some risks and that complications may occur;
- The patient may need an anaesthetic, medicines or blood transfusion, and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risk.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN

Substitute consent

To be completed by the person responsible/guardian

I consent to the procedure/treatment described above for
INSERT NAME OF PATIENT

DELETE IF NOT REQUIRED This part must be countersigned by the doctor if retained

Except that after discussing this matter with the doctor, I do not agree to the patient having the following aspects of the recommended procedure or treatment.
INSERT OBJECTION

.....
PRACTITIONER'S ACKNOWLEDGEMENT

I have considered the views of and consider the treatment should
INSERT NAME OF PATIENT
 be provided to the patient. I am satisfied the treatment will promote the health and wellbeing of the patient.

I accept the risks involved in the procedure/treatment.

I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

I **consent/do not consent*** to a blood transfusion if needed.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN

.....
RELATIONSHIP TO PATIENT IN TERMS OF THE ACT

.....
ADDRESS

Use of removed tissue – (See Section 33 of Circular)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of
INSERT NAME OF PATIENT's condition.

I **consent/do not consent*** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of
INSERT NAME OF PATIENT's condition.

My consent is conditional on the following terms:

.....
(INSERT TERMS, IF ANY)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE

*Delete where not applicable