GUARDIANSHIP ACT 1987 (For patients 16 years and above without capacity)

PROVISION OF INFORMATION TO PERSON RESPONSIBLE

To be completed by Medical Practitioner

1. Dr ........................................................................................................... confirm that .........................................................................................

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................................................................................................................................................

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

The proposed procedure / treatment is

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

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

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

explained:
• that other forms of procedure / 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.

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

I understand that another doctor may perform the procedure / treatment.

I consent            do not consent to a blood transfusion if needed

This part must be countersigned by your doctor as acknowledgment of refusal.

After discussing this matter with the doctor, I do not agree to the patient having the following aspects of the recommended procedure or treatment:

I consent to the procedure / treatment above for

I, Dr ........................................................................................................... confirm that .........................................................................................

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CONSENT − SUBSTITUTE CONSENT FOR MEDICAL PROCEDURE / TREATMENT

SIGNATURE OF MEDICAL PRACTITIONER

DATE                              TIME

SIGNATURE OF PERSON RESPONSIBLE

DATE                              TIME

NO WRITING

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