NSW GOVERNMENT Health

Facility:

CONSENT – SUBSTITUTE CONSENT FOR MEDICAL PROCEDURE / TREATMENT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020002

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

PROVISION OF INFORMATION TO PERSON RESPONSIBLE — **To be completed by Medical Practitioner**

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

The proposed treatment / procedure 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 with these alternatives are:.....

The proposed procedure/treatment is the most appropriate form of procedure/treatment to promote the patient's health and well-being. ..... (NAME OF PERSON RESPONSIBLE) and I have discussed the patient's present condition and I have also 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.

..... (SIGNATURE OF MEDICAL PRACTITIONER) ..... /..... /20..... (DATE) ..... : ..... (TIME)

Interpreter* ..... (PRINT NAME) ..... (SIGNATURE) ..... /..... /20..... (DATE) ..... : ..... (TIME) ..... (Emp ID/Prov No.)

SUBSTITUTE CONSENT — **To be completed by the person responsible**

Dr ..... (INSERT NAME OF MEDICAL PRACTITIONER) and I have discussed the matters above.

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

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

I have considered the views of ..... (INSERT NAME OF PATIENT) and am satisfied the treatment will promote the health and wellbeing of the patient.

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

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

I **consent** to the procedure / treatment above for ..... (INSERT NAME OF PATIENT)

DELETE IF NOT REQUIRED *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:* ..... (INSERT OBJECTION)

.....

.... (SIGNATURE OF MEDICAL PRACTITIONER)

☐ **I consent** ☐ **do not consent to a blood transfusion if needed**

..... (SIGNATURE OF PERSON RESPONSIBLE) ..... /...../20..... (DATE)

..... (PRINT NAME OF PERSON RESPONSIBLE) ..... (RELATIONSHIP TO PATIENT IN TERMS OF THE ACT)

..... (ADDRESS OF PERSON RESPONSIBLE) ..... (PHONE NUMBER OF PERSON RESPONSIBLE)

* Delete where not applicable

NH606007 171218

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

CONSENT – SUBSTITUTE CONSENT FOR MEDICAL PROCEDURE / TREATMENT

SMR020.002

NO WRITING