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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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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Director-General
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)

Medical Advice

To be completed by Medical Practitioner

I, Dr ......................................................... confirm that ......................................................... is incapable of consenting to medical treatment because:

☐ he/she cannot understand the nature and effect of the treatment

(Tick one) 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

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

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

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

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

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

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.

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

SIGNATURE OF PERSON RESPONSIBLE                  DATE                  SIGNATURE OF MEDICAL PRACTITIONER                  DATE

Interpreter present *

.............................................................   ...../...../20.....    ........................................ .....................   ...../...../20.....

SIGNATURE OF INTERPRETER                                                     DATE
Acknowledgement of advice
To be completed by the person responsible/guardian

Dr ........................................................................ and I have discussed ..................................................’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. ..........................................................

..................................................................................................................................................................
PRACTITIONER’S ACKNOWLEDGEMENT

I have considered the views of ................................................................. and consider the treatment should 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.

..................................................................................................................................................................
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 .................................................................’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 .................................................................’s condition.

My consent is conditional on the following terms:

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

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

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

*Delete where not applicable