StVincent's LISMORE

SUBSTITUTE CONSENT FOR MEDICAL PROCEDURE/TREATMENT

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

❑ Day Only

❑ In-Patient

❑ DOH ❑ Workers Comp

❑ DVA ❑ Private

❑ MVA ❑ Uninsured

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 ..... 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 .....

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

.....

.....

Planned CMBS Item Number(s) .....

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

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 treatment 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.....
SIGNATURE OF MEDICAL PRACTITIONER — DATE

Interpreter present ..../...../20.....
PRINT NAME — SIGNATURE — DATE

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

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

I understand the nature of the procedure/treatment and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I have considered the views of .....and am satisfied the treatment will promote
INSERT NAME OF PATIENT

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

DELETE IF NOT REQUIRED *(This part must be countersigned by your doctor as acknowledgement 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

....
Medical Practitioner's Acknowledgment

❑ **I CONSENT** ❑ **I DO NOT CONSENT to a transfusion of blood and/or blood products if needed**

..../...../20.....
SIGNATURE OF PERSON RESPONSIBLE — DATE

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

....
ADDRESS OF PERSON RESPONSIBLE — PHONE NUMBER OF PERSON RERSPONSIBLE

BINDING MARGIN – DO NOT WRITE

CONSENT – SUBSTITUTE CONSENT