HSS TRUST _____ | GP PRACTICE or other_____

Hospital Unit _____ | Primary Care Provider_____

FORM 4 -- ADULTS WHO ARE UNABLE TO CONSENT TO EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name .....

First names .....

Date of Birth .....

❑ Male ❑ Female H+C No. (or other identifier) .....

Special requirements (language or other) .....

.....

Statement of healthcare professional

Responsible healthcare professional .....Job Title.....

Name of proposed procedure or course of treatment *(include site if body or site and brief explanation if medical term not clear)*

.....

.....

B. Assessment of adult's capacity

I confirm that the person named above lacks capacity to give or withhold consent to this procedure or course of treatment or care because he or she :

☐ is unable to comprehend and retain information material to the decision and/or

☐ is unable to use and weigh this information in the decision-making process or

☐ is unconscious

Further details (excluding where patient unconscious); for example how above judgements reached; which colleagues consulted; what attempts made to assist the individual make his or her own decision and why these were not successful.

.....

.....

C. Assessment of best interests

To the best of my knowledge, the person named above has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to him/her; and I believe the procedure to be in his/her interests because:

.....

.....

(Where incapacity is likely to be temporary, for example if patient unconscious, or where he/she has fluctuating capacity)

The treatment cannot wait until the he/she recovers capacity because:

.....

.....

D. Involvement of the family and others close to him/her

The final responsibility for determining whether a procedure is in an incapacitated person's best interests, lies with the healthcare professional performing the procedure. However, it is good practice to consult with those close to the person (eg. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that he/she would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical practice", and include factors such as their wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the individual, if they wish)

I/we have been involved in a discussion with the relevant healthcare professionals over the care and treatment of .....(name). I/we understand that he/she is unable to give his/her consent, based on the criteria set out in this form. I/we also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision).....

.....

Name.....Relationship to person .....

Address (if not the same as above).....

.....

Signature .....Date .....

If a person close to the individual was not available in person, has this matter been discussed in any other way (eg. over the telephone) ❑ Yes ❑ No

Details:.....

.....

Signature of healthcare professional proposing treatment

The above procedure is, in my professional judgement, in the best interests of the person named above, who lacks capacity to consent for himself or herself. Where possible and appropriate, I have discussed his/her condition with those close to him or her, and taken their knowledge of his/her views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature .....Date.....

Name (PRINT) .....Job Title .....

Where second opinion sought, he/she should sign below to confirm agreement:

Signature .....Date .....

Name (PRINT) .....Job Title .....