NOVA SCOTIA
Office of the Public Trustee
Health Care Decisions Division

Request for Consent for Subsequent* Psychiatric Treatment

Pursuant to the *Hospitals Act and Involuntary Psychiatric Treatment Act*

*** Note:** This form is for second and subsequent referrals for psychiatric and medical treatment during the same hospitalization. Initial referrals for psychiatric treatment *must* be made using the Request for Consent Psychiatric Treatment available at www.gov.ns.ca/just/pto/forms. **Please contact the Health Care Decisions Division at (902) 424-4454 if you require assistance.**

Give client information

Client's Full Name: _____ Health card #: _____

Hospital: _____ Admission date: _____

Give information about this request for consent

Diagnoses or health problems which are relevant to this request: _____

What are you requesting? Please complete page 2 if medications are included in this request _____

Benefits _____

Risks _____

What are the risks of refusing this treatment? _____

Is there a less restrictive or intrusive option available that would give the same benefit but is less risky than this option? Explain.

Supporting information Please check if attaching existing documentation that would support this request (report, progress notes) ☐

Sign the request

By signing below, I verify that this client lacks the capacity to make an informed decision about the proposed treatment and that the Form A - Declaration of Capacity to Consent to Treatment (*Hospitals Act*) previously submitted during this hospitalization remains valid. I also verify that no higher-ranked statutory decision maker has been identified since the last referral during this hospitalization.

This treatment will be provided by me or under my supervision or by or under the supervision of _____ ,

a qualified psychiatrist at _____ Hospital.

Psychiatrist's signature _____ Registration/License number _____

Date _____ Phone: _____ Fax: _____

Fax request to: Health Care Decisions Division **(902) 428-2159**

Complete this page if this request includes medications

Client name: ______________________________ **Date:** ______________________________

Medication	Dose, Frequency, Route
Purpose Risks and possible side effects: Is there an alternative that would give the benefit but that is not as risky? Has the client taken this medication before? ❑ Yes ❑ No ❑ Unknown If yes, how did it work? What would happen if consent refused?	
Medication	Dose, Frequency, Route
Purpose Risks and possible side effects: Is there an alternative that would give the benefit but that is not as risky? Has the client taken this medication before? ❑ Yes ❑ No ❑ Unknown If yes, how did it work? What would happen if consent is refused?	
Medication	Dose, Frequency, Route
Purpose Risks and possible side effects: Is there an alternative that would give the benefit but that is not as risky? Has the client taken this medication before? ❑ Yes ❑ No ❑ Unknown If yes, how did it work? What would happen if consent is refused?	
Medication	Dose, Frequency, Route
Purpose Risks and possible side effects: Is there an alternative that would give the benefit but that is not as risky? Has the client taken this medication before? ❑ Yes ❑ No ❑ Unknown If yes, how did it work? What would happen if consent is refused?	
Medication	Dose, Frequency, Route
Purpose Risks and possible side effects: Is there an alternative that would give the benefit but that is not as risky? Has the client taken this medication before? ❑ Yes ❑ No ❑ Unknown If yes, how did it work? What would happen if consent is refused?	

Copy this form for additional medications, as required.