NOVA SCOTIA

Public Trustee Office
Health Care Decisions Division

Request for Consent for Medical or Surgical Treatment

Pursuant to the *Hospitals Act*

1. Give client information

First name: _____ Middle name: _____ Last name: _____

Date of birth (dd/mm/yyyy): _____ Health Card Number: _____

Address: _____

_____ Postal code: _____

Family Physician: _____ Phone number: _____

2. Does this person lack capacity to make this decision?

Has a physician assessed this person and found that the person lacks the capacity to make this decision? ☐ Yes ☐ No

Is the person's incapacity permanent? ☐ Yes ☐ No ☐ Unknown

3. Does this person have any known relatives or someone legally authorized to make medical decisions for this person?

Court-appointed guardian? ☐ Yes ☐ No

Medical Proxy (named under the *Medical Consent Act* prior to April1 2010)? ☐ Yes ☐ No

Delegate named in a Personal Directive? ☐ Yes ☐ No

Known relatives? ☐ Yes ☐ No

If yes, tell why relative, delegate, or proxy is not making the decision _____

_____

_____

4. What decision needs to be made?

☐ medical treatment ☐ surgical treatment ☐ This is an urgent request.

5. Give information about this person's wishes, values or beliefs

Does the person have a Personal Directive? ☐ Yes ☐ No ☐ Unknown

Give any information about the person's ethnic, cultural or religious background that may apply to this decision.

_____

_____

Give any information that the person may have expressed when capable that may apply to this decision.

_____

_____

6. Give information about this request for consent

Medical diagnoses or health problems which are relevant to this request: _____

_____

_____

What are you requesting? _____

_____

_____

_____

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.

_____

_____

7. Surgical Treatment (You must also complete Section 6 above)

Date of surgery _____ Type of anesthesia _____

Has this person had general anesthetic in the past? ☐ Yes ☐ No ☐ Unknown

If yes, were there any side effects or post-operative complications? ☐ No If yes, describe _____

_____

What are the anesthesia risks for this person? _____

_____

_____

What are the surgical risks for this person? _____

_____

8. Attach required and supporting documents.

Required

1. Copy of the person's Personal Directive ☐ Attached ☐ No known personal directive
2. Form A - Declaration of Capacity to Consent to Treatment (*Hospitals Act*) ☐ Attached ☐ Previously submitted & still valid
3. Signature of physician or surgeon in Section 9

Supporting *Please attach existing documentation that would support this request.*

☐ report ☐ progress notes / assessment ☐ admission history & physical ☐ medication order sheet

☐ Substitute Decision-maker Identification form - available at www.gov.ns.ca/just/pto/forms

9. Sign the request.

Form completed by (print): _____ Agency: _____

Alternate contact (please print): _____

Address: _____ Nova Scotia

Postal Code: _____ DHA _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

Signature of Physician / Surgeon

This medical or surgical treatment will be administered by me (please print) _____ or under my supervision or by or under the supervision of (please print) _____ , a qualified physician at _____ Hospital.

Physician's signature _____ Registration/License number _____

Date _____ Phone: _____ Fax: _____

10. Return the form and attachments to

Health Care Decisions Division

Confidential Fax: **902-428-2159**

Questions?

Call: **902-424-4454**

E-mail: PublicTrusteeHCD@gov.ns.ca

Web: www.gov.ns.ca/just/pto

For Office use only

11. Complete 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?	

Copy this form for additional medications, as required.