NOVA SCOTIA

Public Trustee Office
Health Care Decisions Division

Request for Consent for Psychiatric Treatment

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

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 treatment decisions for this person?

Court-appointed guardian?	☐ Yes	☐ No
Medical Proxy (named under *Medical Consent Act* prior to April1 2010)	☐ Yes	☐ No
Delegate named in a Personal Directive?	☐ Yes	☐ No
Known relatives?	☐ Yes	☐ No

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

_____

_____

4. What decision needs to be made?

Is this request urgent - decision required within 24 hours? ☐ Yes

☐ psychotropic medication ☐ community treatment order / renewal ☐ electroconvulsive therapy

☐ other medication ☐ care plan / inpatient care ☐ other _____

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 they were capable that may apply to this decision.

_____

_____

6. Give information about this request for consent (please complete this section for all referrals)

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 treatment? Explain.

_____

_____

7. Electroconvulsive therapy (ECT) ☐ N/A

What type of anesthesia is required? _____

What are the anesthesia risks for this person? _____

Has this person had ECT before? ☐ Yes ☐ No ☐ Unknown If yes, what was its effect? _____

_____

Give the expected ECT treatment schedule _____

The ECT treatments will be administered by (please print) _____ , a qualified psychiatrist at _____ hospital.

8. Community Treatment Order ☐ N/A

The services required by this person and outlined in the attached Form 9 - Community Treatment Order (IPTA s. 47) exist in the community and are available to the client and will be provided to the client. ☐ Yes ☐ No

9. Community Treatment Order Renewal ☐ N/A

The services required by this person and outlined in the attached Form 10 – Renewal of Community Treatment Order exist in the (IPTA s. 52) community and are available to the client be provided to the client ☐ Yes ☐ No

10. Attach required and supporting documents

Required

Copy of the person's Personal Directive	☐ attached	☐ no known personal directive
Form A - Declaration of Capacity to Consent to Treatment (*Hospitals Act*)	☐ attached	☐ previously submitted & still valid
Form 4 - Declaration of Involuntary Admission (IPTA)	☐ attached	☐ N/A
Form 9 - Community Treatment Order (IPTA)	☐ attached	☐ N/A
Form 10 - Renewal of Community Treatment Order (IPTA)	☐ attached	☐ N/A

Supporting – *please attach existing documentation that would support this request.*

☐ report ☐ progress notes / assessment ☐ medication order sheet ☐ Substitute Decision-maker Identification form

11. Contact information and Signature

Hospital/Agency:_____ Contact person: _____

Address: _____ Postal Code: _____

DHA: _____ Phone: _____ Fax: _____

Psychiatrist's signature for psychiatric treatment including ECT ☐ N/A

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

_____	_____	_____
Psychiatrist's signature	Registration/License number	Phone

Psychiatrist's signature for community treatment orders or renewals ☐ N/A

This community treatment plan will be supervised and managed by me (please print)_____ or under the supervision of (please print) _____ , a qualified psychiatrist who has agreed to carry out my responsibilities in my absence.

_____	_____	_____
Psychiatrist's signature	Registration/License number	Phone

12. Return the form and attachments to:

Health Care Decisions Division

By Confidential Fax: (**902) 428-2159**

Questions?

Call: 9(02) 424-4454 **E-mail:** PublicTrusteeHCD@gov.ns.ca **Web:** gov.ns.ca/just/pto/

13. Complete if this request includes medications

CLIENT: 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.