NHS number:

Name of patient:

Address:

Date of birth:

CR number:

AFFIX PATIENT LABEL

Royal Cornwall Hospitals NHS
NHS Trust

CONSENT FORM 4

For use in Cornwall

Form for adults who lack the capacity to consent to investigation or treatment

Patient's surname/family name:

Patient's first name(s):

Male ☐ Female ☐

Special Requirements (e.g. other language, other communication method etc.)

Date of birth:

NHS number (or other identifier)

Responsible health professional

Job title

All sections to be completed by health professional proposing the procedure

A Details of procedure or treatment proposed

(See guidance to health professionals on separate insert for details of situations where court approval must first be sought)

B Assessment of patient's capacity (in accordance with the Mental Capacity Act)

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment, because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works. For example, a disability, condition or trauma, or the effect of drugs or alcohol and they cannot do one or more of the following:

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- understand information about the procedure or course of treatment
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

C Assessment of patient's best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision.

As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down) and any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient's best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

Where the lack of capacity is likely to be temporary, the treatment cannot wait until the patient recovers capacity because:

D Involvement of those close to the patient

The final responsibility for determining whether a procedure is in the best interest of the patient who lacks capacity lies with the health professional performing the procedure (unless the patient has an attorney or deputy, see section E). However,

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you must consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) as far as is practicable and as appropriate.

To be signed by a person or persons close to the patient, if they wish.

I/We have been involved in a discussion with the relevant health professionals over the treatment of ..... (patient's name). I/We understand that he/she is unable to give their own 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 the decision):

_____

_____

Signature _____ Date _____

Name (PRINT) _____

Relationship to patient _____

Address _____

_____

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone)?

Yes ☐ No ☐

Details:

_____

_____

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Independent Mental Capacity Advocate (IMCA)

For decisions about serious medical treatment, where there is no one appropriate to consult other than paid staff, has an Independent Mental Capacity Advocate (IMCA) been instructed?

Yes ☐ No ☐

Details:

Signature _____ Date _____

E The patient has an attorney or deputy

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Signature of attorney or deputy

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient's best interests.

Any other comments (including the circumstances considered in assessing the patient's best interests):

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Signature _____ Date _____

Name (PRINT) _____

Relationship to patient _____

Address _____

_____

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for themself. Where possible and appropriate I have discussed the patient's condition with those close to him/her and taken their knowledge of the patient's views and beliefs into account in determining his/her best interests.

I have/have not sought a second opinion.

Signature _____ Date _____

Name (PRINT) _____

Job title _____

When a second opinion was sought, she/he should sign below to confirm agreement:

Signature _____ Date _____

Name (PRINT) _____

Job title _____