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**Whittington Health CONSENT FORM 4**

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

Patient’s surname.................................Patient’s first names........................………

Date of birth.......................................NHS / hospital number....................……………..

Male Female Special requirement (language/communication method)

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Responsible health professional..................................................................................

Job title.................................................................................................................. …..

**All sections to be completed by the consultant who requested the procedure and countersigned by a second clinician carrying out the operation, investigation or treatment.**

**A) Details of procedure or course of treatment proposed**

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**(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)**

**B) Assessment of patient’s capacity**

**I confirm that the patient lacks capacity to give consent to this procedure or course of treatment because at the time of my assessment the patient is unable to understand, retain (for long enough to reach the decision), use or weigh the information required to reach a decision and communicate this decision.**

Further details of medical condition that renders patient incapable of a decision, how and what information was given to the patient and what further efforts were made to enable the patient to reach their own decision (see clinical guidelines “Capacity and Consent” on hospital intranet for suggestions of good practice).

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**C) The patient has a registered Lasting Power of Attorney for personal welfare decisions and that LPA allows the Attorney named in the LPA to make decisions on behalf of the patient in this situation (note: the existence of a relevant Lasting Power of Attorney is only relevant to the consent process if the patient lacks capacity to make this particular decision at the time of the assessment).**

Record the scope of LPA in relation to the personal welfare decisions (this written information should be available from the LPA):

Details of Attorney assessment of the patient’s best interests

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Name of Attorney consenting to procedure/treatment PRINT:

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Date:……………………………………………………………………………………………

Signature of Attorney:………………………………………………………………………

Address:………………………………………………………………………………………

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Name of Health Professional:………………………………………………………………

Date:……………………………………………………………………………………………………

Signature………………………………………………Designation…………………………

**D) Assessment of patient’s best interests**

**To the best of my knowledge, the patient has not refused this procedure in a valid advance directive and there is no valid Lasting Power of Attorney in place. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient’s best interests because:**

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

**The treatment cannot wait until the patient recovers capacity because:**

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**Involvement of the patient’s family and others close to the patient. Please note**, in the absence of a valid Advanced Directive, Court Order or a Lasting Power of Attorney, the final responsibility for determining whether a procedure is in an incapacitated patient’s best interest lies with the health professional performing the procedure.

However, unless it is impractical or inappropriate to do so, it is necessary to consult with those who are close to the patient (e.g. spouse/partner family and friends, carer, Attorney of Lasting Power of Attorney, supporter or advocate) Where there is no next of kin, it is necessary to appoint an Independent Medical Capacity Advocate (see guidelines on intranet).It is necessary to take into account the patient’s own past wishes and feelings, beliefs and values unless the urgency of the situation prevents this. ‘Best interests’ go far wider than ‘best medical interest’, and include factors such as the patient’s wishes and beliefs when competent, their current wishes, their general wellbeing and their spiritual and religious welfare.

**The procedure has/has not been discussed with the patient’s next of kin, relatives or**

**carers/ IMCA. (delete as necessary).**

Signed by health professional……………………………………………………………

**Please note: the patient’s next of kin cannot sign this form on the patient’s behalf.**

**F) 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 him or herself. Where possible and appropriate I have discussed the patient’s condition with those close to him or her, and taken their knowledge of the patient’s views and beliefs into account in determining his or her best interests.

**Name of consultant requesting the procedure.**

(PRINT) …………………………… ……………………………

Signature……………………………………….

Designation……………………………

Date………………………………….…………

**Name of second clinician carrying out the procedure**

(PRINT) …………………………… ……………………………

Signature………………………………..………

Designation…………………………… ……………………………….

Date…………………………………...