Report to the Public Guardian regarding a health care decision maker

Under the provisions of section 56 of the *Health Care Decision Making Act 2023*, this form is to be used to notify the Public Guardian that a health care decision maker is both:

* refusing to consent to ‘significant’ treatment; and
* does not know the wishes and views of the person.

All other scenarios and concerns regarding decision makers should be directed to the Northern Territory Civil and Administrative Tribunal (NTCAT)

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| **Before completing this form please ensure your initial responsibilities as a health care provider are fulfilled.**  *Refer to our guideline* [*Initial responsibilities of a health care provider*](https://pgt.nt.gov.au/sites/default/files/initial_responsibilities_of_a_health_care_provider_guideline.pdf) *for further information*   1. **Does the person have an Advance Personal Plan (APP)?** Yes  No   *If yes please attach a copy of the APP*   1. **Does the APP include an advance care decision in relation to the health care required?** Yes  No   *If yes, the health care provider has authority to administer health care to a person with impaired decision making capacity in accordance with the person's advance consent decision.*   1. **Does a health care decision maker need to make the decision in the circumstances?**   *Please review our flowchart –* [*Adult health care consent*](https://pgt.nt.gov.au/sites/default/files/adult_patient_consent_flowchart.pdf).  *Note - The health provider must keep a written record of the provider’s efforts to ascertain if the person has an APP.* |

1. Person’s details

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname | | Given names | | | DOB | Gender *(click to select)* | | HRN | |
|  | |  | | |  |  | |  | |
| Address | | | Suburb/Town | | | | State/Territory | | Post code |
|  | | |  | | | |  | |  |
| Telephone (m) | Telephone (h) | | Email address | | | | | | |
|  |  | |  | | | | | | |
| Country of birth | Interpreter required | | | Preferred interpreter language | | | | | |
|  | Yes  No | | |  | | | | | |

Does the person identify as Aboriginal and/or Torres Strait Islander?

Yes  No  Unknown

Is the person currently an involuntary patient under the *Mental Health and Related Services Act 1998*?

Yes  No

1. Person recommending the health care

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| --- | --- | --- | --- | --- | --- | --- |
| Surname | | Given name | | Role/Job title | | |
|  | |  | |  | | |
| Health Care Provider | | | | | | |
|  | | | | | | |
| Address | | | Suburb/town | | State/Territory | Post code |
|  | | |  | |  |  |
| Telephone (M) | Telephone (W) | | Email Address | | | |
|  |  | |  | | | |

1. Health care decision maker(s)

*Health care decision maker(s) refusing consent e.g. Guardian, appointed decision maker under an APP, relative, spouse/partner, carer etc.*

Interested parties list e.g*. Guardian, appointed decision maker under an APP, relative, spouse/partner, carer etc.*

| Full name | Relationship | Contact no: | Email |
| --- | --- | --- | --- |
|  |  |  |  |
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1. Notification

Provide an overview of the proposed health care

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Why do you believe the preferences and values of the person are not known or unable to be known by the health care decision maker?

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Have you discussed the proposed health care with the person requiring treatment (including anaesthetic)?

Yes ☐ No ☐

What are the person’s views about the proposed health care?

*If unable to communicate, is there any indication of what their views would be (an advance care statement in an APP, views of interested parties may assist)*

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Thank you for taking the time to complete the details above.

Please email your completed form to: [pgt.health@nt.gov.au](mailto:pgt.health@nt.gov.au)