Health Care Decision Request Form

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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. **Have attempts been made to contact the appropriate health care decision maker, including currently appointed Guardian or decision maker under an APP?**   *Refer to our guideline,* [*Determining the appropriate health care decision maker*](https://pgt.nt.gov.au/sites/default/files/pgt_-_determining_the_appropriate_health_care_decision_maker_guideline.pdf) *for further information*  Was an appropriate health care decision maker identified? Yes  No   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 and/or to contact the appropriate health care decision maker(s).* |

1. Person’s details

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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

Accommodation type *(click to select)*

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Support circumstances

*Please provide brief detail on the following, if known*

* *Funded supports – NDIS, Aged care, other*
* *Informal supports – family, friends*
* *Circumstances leading to current admission*

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1. Person recommending the health care

*Please note, the person who would administer the health care must also determine decision making capacity – evidence to be provided in Part 3 below.*

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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 | | | |
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**Other health care providers directly providing the health care**

*(e.g., consultant responsible, surgeon, anaesthetist)*

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| Full name | Role | Contact no: | Email |
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1. Decision making capacity

*All adults are presumed to have capacity to make health care decisions unless there is evidence to the contrary.*

*Reasonable efforts should be made to provide practicable support to alleviate the effects of the adult’s disability in order to accurately assess decision making capacity.*

*Refer to our guideline* - [*Determining decision making capacity for a health care decision*](https://pgt.nt.gov.au/sites/default/files/pgt_-_determining_decision_making_capacity_for_a_health_care_decision_guideline.pdf) *for more information*.

| Communication needs *(click to select option)* | Communication support/adjustments provided *(click to select option)* |
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Diagnosis or condition contributing to impaired decision making capacity

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Describe how you assessed that the person has impaired capacity to make this particular health care decision?*Attach relevant assessments/documentation*

*Note - Past assessments and/or a Guardianship Order are not determinative of impaired decision capacity for health care decisions. Evidence must demonstrate the extent of the adult’s impairment in relation to the specific decision needed within the current circumstances.*

*Extent of impairment related to the decision in any of the following areas is relevant:*

1. *understanding and retaining information relevant to the health care decision (after explained to them in a way that is appropriate to the adult e.g. visual aids)*
2. *weighing information relevant to the health care decision in order to make the health care decision;*
3. *communicating the health care decision in some way (after appropriate communication support provided);*
4. *understanding the effect of the health care decision.*

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1. Health care decision maker(s)

*Health care providers must make reasonable efforts in the circumstances to contact the appropriate health care decision maker for the person with impaired decision making capacity.*

*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 more information.*

Why the current health care decision maker(s) cannot make this decision? *(e.g. uncontactable, dispute, contrary actions)*

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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. Health care decision

Date of proposed treatment*(if no date select approximate/expected date)* Click or tap to enter a date.

Could the health care be safely delayed until the adult is able to make the decision? Yes  No

Is the health care considered ‘significant’? *Refer to our guideline* [*Routine health care*](https://pgt.nt.gov.au/sites/default/files/pgt_-_routine_health_care_guideline.pdf) *for more information*

The recommended health care: *(tick which applies)*

is objected to by the adult; or

consists of an ongoing course of treatment; or

causes a significant degree of intrusion into the body of the adult; or

creates a significant risk of harm to the adult; or

causes significant side-effects to the adult; or

causes significant pain or distress to the adult.

Is this an end of life decision?Yes  No

Diagnosis/problem?

*Including relevant medical history (comorbidities, medications, surgeries etc.)*

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Proposed health care to be provided?

*Please include detail on the following where relevant*

* *Describe the health care needed and how is proposed to be carried out*
* *Alternatives to the proposed medical treatment?*
* *Would the same procedure be being recommended if the person did not have impaired decision making capacity?*

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Are Restrictive Practices proposed?Yes  *if yes please outline below* No Unsure

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Describe the likely effects (benefits) of the health care

*Please include detail on the following where relevant*

* *Purpose of the health care - cure/relief/investigation*
* *Why the treatment/procedure is recommended?*

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Describe the consequences (risks)

*Please include detail on the following where relevant*

* *Risks of the proposed health care*
* *Risks to the persons quality of life*
* *Risks of not proceeding with the health care*

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Anaesthetic detail

Type of anaesthetic to be used

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How is it administered?

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General and specific risks/side effects to the person

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1. Views

Has the health provider discussed the proposed health care with the person (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)