

2.3
 Person Responsible: MEDICAL
 AND DENTAL CONSENT

Name:
 Address:
 D.O.B:

I **do** / **do not** (*please circle*) wish to be the person responsible to consent to medical and dental treatments for _____ when they are unable to provide informed consent to a medical or dental treatment.

I understand that the treatments that I consent to must be for the purpose of promoting or maintaining the health and wellbeing of this person. I understand that if treatment is urgently needed to save this persons life or to prevent serious damage to his/her health, a doctor may proceed without my consent. I understand that if "special" medical treatments are proposed, the consent of the Guardianship Board must be obtained. I understand that I cannot override the objections of this person without authorization from the Guardianship Tribunal.

Name : _____
person responsible

Signature: _____
person responsible

Date: / /

Relationship to service user: _____

I prefer to be contacted by: Home Work Mobile Fax Email Post
 Tick 1 or more options and list details below

Home: _____ Work: _____

Mobile: _____ Fax: _____

Email Address: _____

Postal Address: _____
Street name and number

_____ *Suburb* *State* *Postcode*

Please advise the service if your contact details change

TICK WHEN COMPLETED

(OFFICE USE ONLY)

- Details in individual file/Medication file and service directory have been updated if required
- Record receipt of nomination form in the Case Notes
- Provided person responsible with information sheet (doc_160_person_responsible_may_09.pdf)

Review Due Date:

Version: 2.0