Draft #2 April 2016

Confirmation of need to detain and provide emergency medical care to an adult without his/her consent.

(As per BC Health Care Consent and Care Facility Admission Act)

I, _____ examined
Name and profession of registered Health Care Provider,

_____ on _____.
name of patient *dd / mm / yyyy*

1. In my opinion, it is necessary to provide health care without delay (i.e. emergently) in order to preserve this person's life, to prevent serious physical or mental harm or to alleviate severe pain.

2.This person has not demonstrated a clear understanding of his/her current health predicament, and is therefore in my judgment incapable of providing informed consent to, or informed refusal of, necessary emergency care. I have attempted but am unable to confirm that he/she understands the nature of his/her medical situation and the nature of the proposed treatment, including the risks, benefits, and alternatives.

3. There is no readily available personal guardian or representative who is authorized to consent to health care on this person's behalf and is capable of doing so.

4. I am unaware of any previously expressed wish or advance directive that would lead me to conclude that this person would not accept the proposed care. (e.g. living will declining resuscitation, refusal of blood products, etc).

5. This person would not be more appropriately detained under the Mental Health Act, i.e. does not appear to require involuntary treatment of a mental disorder in a psychiatric facility.

A. The following medical condition requires emergent investigation and/or treatment: (e.g. suspected sepsis, head injury, vascular catastrophe/shock, altered mental status).

_____

_____

_____

B. The following investigations/therapies are emergently required to properly diagnose/and or treat this condition: (e.g. lab, imaging, emergency medicine procedures, medications)

_____

_____

C. The following clinical features appear to be imparing this patients ability to provide informed refusal of care (e.g. drug or alcohol intoxication or withdrawal, shock, head injury, psychiatric illness, metabolic abnormality, sepsis, hypoxia).

_____

_____

Signed _____
Signature of Health Care Worker *Date and time*_____

Note: This form conforms to the criteria set out in Section 12 of BCs HCCCFA, and can initially be completed by any Licensed Care Professional as defined in the HCCCFA (physician, nurse, licensed practical nurse, social worker, etc), but should subsequently be completed by the attending physician.