Request for consent to a level of care

Curateur public
Québec

General information

Person concerned

Last name	First name

Date of birth yyyy-mm-dd	No of the Curateur public's file (if known)

Person making the request

Last name	First name

Function	Telephone	Ext.	Fax

Email

Name of the institution

Address no, street, city	Postal code

Person to whom to return consent

Last name	First name

Function	Telephone	Ext.	Fax

Email

Name of the institution

Address no, street, city	Postal code

Request for consent to a level of care

Ability of the person concerned to consent to the proposed level of care

Important : Being represented does not prevent the person from consenting to getting care. The professional proposing the level of care must assess the person's ability to consent to the proposed level of care. If the person is able to do so, it is only that person who consents, not the Curateur public.

The person was assessed:

☐   **able** to consent.

    If the professional assesses the person as being able to consent, no request is needed. However, if the person is represented by the Curateur public, we wish to be informed about this. To do so, contact the Direction médicale et du consentement aux soins at 514 873-5228.

☐   **unable** to consent.

    Does the person have a guardian other than the Curateur public?

    ☐   **Yes.** Ask for their consent. If you do not know the contact information for the guardian, contact the Curateur public at 514 873-4074 or 1 844 LECURATEUR (532-8728).

    ☐   **No.** Please complete the following sections.

Last name of the physician proposing the level of care	First name

Proposed level of care (Please attach your institution's model to this request.)

Exchange of information with the person who is unable to consent

The individual:

☐   was informed in a manner consistent with their communication abilities.

    Result of the exchange, including the wishes and preferences of the individual unable to consent:

    _____
    _____
    _____

☐   was not informed. Justification:

    _____
    _____

Has the individual ever reported:

- current or past wishes?   ☐ Yes (specify):   ☐ No

- advanced medical directives (AMD) registered with the RAMQ?   ☐ Yes (specify):   ☐ No

Request for consent to a level of care (continued)

Exchange of information with a relative

☐ A relative was informed.

Last name of the relative	First name

Relationship to the individual unable to consent

Result of the exchange, including the represented person's previously expressed wishes and preferences, if known.

_____
_____

Clinical description

Clinical condition that justifies the choice of this level of care

_____
_____

Diagnosis and medical history

_____
_____

General profile

Ability to express needs, judgment and cognition

_____
_____

Mobility

_____
_____

Continence

_____
_____

Autonomy in eating, bathing and dressing

_____
_____

Activities

_____
_____

Collaborative care

_____
_____

_____
Physician's signature and date