Physician Certification/Efforts to Locate Person Form

These forms are to be used only by ICF/IID health care providers pursuant to the Adult Health Care Consent Act (S.C. Code Ann. § 44-66-10)

Patient's Name:_____ DOB:_____

Section I. Proposed Health Care and Timeframe for Initiation

_____

_____

Section II. Certification by Physician

A. Based on examination, it is my professional opinion that the person named above (*choose one*):

☐ **Is** able to give valid consent for the proposed health care.

☐ **Is temporarily not** able to consent for the proposed health care.

☐ **Is not** able to give valid consent for the proposed health care.

B. This person is noted to be: ☐ **temporarily not** able or ☐ **not** able to give valid consent *(indicate why)* He/she: (*check all that apply*):

☐ Is unable to appreciate the nature and implications of his/her conditions and the proposed health care;

☐ Is unable to make a reasoned decision concerning the proposed health care; or

☐ Is unable to communicate a decision concerning the proposed health care in an unambiguous manner.

C. This person is noted to be: ☐ **temporarily not** able or ☐ **not** able to give valid consent and the following facts and observation that support this medical opinion and conclusion include:

1. The **cause** of the person's inability to consent is:_____
2. The n**ature** of the person's inability to consent is:_____
3. The **extent** of the person's inability to consent is:_____
4. The **probable duration** of the person's inability to consent is:_____

D. **If noted to be temporarily unable to consent, will a delay in rendering** the proposed health care beyond the time noted present a substantial risk of death, impairment of functioning of a bodily organ or other serious threat to the health and safety of the person named?: ☐ Yes ☐ No ☐ N/A

I, the undersigned, hereby state than I am a licensed physician and have personally examined the above named person and my opinion and conclusions are stated above.

_____ _____

Signature of Physician Printed Name of Physician

Date:_____

Efforts to Locate Authorized Person

When an adult is certified by two (2) physicians to be unable to consent to health care, an authorized person must be selected from the statutory list of priorities established by S.C. Code Ann. § 44-66-10, et. seq. (2018) and DDSN Directive 535-07-DD: ***Obtaining Consent for Individuals Regarding Health Care.*** *The Priority Categories in this document are listed in priority order, 1-10. When the person has been certified by two (2) physicians to be unable to consent to the proposed health care, the person, among all who are listed, who is identified in the highest priority category and who is reasonably available, willing to make the health care decision for the person and is him/herself able to consent, will be considered the authorized person who can make the decision regarding the proposed health care.*

The selected **Authorized Person**(s):

Name(s):_____

Relationship (priority category) to the person: _____

Address *(include zip code)*:_____

Phone Number *(include area code)*: _____

If someone from any higher priority category was not selected as the authorized person, enter the person's name, the priority category, and the reason he/she was not selected *(e.g., not reasonably available, not willing, unable to consent).*

Priority Category	Name	Reason Not Selected

_____ _____

Printed Name of Health Care Provider | Title of the Health Care Provider

_____ _____

Signature of the Health Care Provider | Date of Completion