ADULT HEALTH CARE CONSENT

Physician Certification

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:_____