

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 **nature** 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 that 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: _____