COVID-19 Therapeutic Drugs Consent

Adult (18 years and over)

Facility: __________________________

A. Therapeutic drug details

Name of therapeutic drug: __________________________

B. Does the person have capacity?

☐ Yes ➔ GO TO section C
☐ No ➔ COMPLETE section B

You must adhere to the Advance Health Directive (AHD), or if there is no AHD, the consent obtained from a substitute decision-maker in the following order: Category 1. Tribunal-appointed guardian; 2. Enduring Power of Attorney; or 3. Statutory Health Attorney.

Name of substitute decision-maker: __________________________
Category of substitute decision-maker: __________________________

C. Is an interpreter required?

☐ Yes ➔ COMPLETE section C
☐ No ➔ GO TO section D

If yes, the interpreter has:
☐ provided a sight translation of the informed consent form in person
☐ translated the informed consent form over the telephone

Name of interpreter: __________________________
Interpreter code: __________________________
Language: __________________________

D. Person/substitute decision-maker consent

I acknowledge that:
• The doctor/clinician has explained to me the risks and benefits of having this COVID-19 therapeutic drug.
• I have read and understood the patient information sheet which includes details regarding all known and potential side effects associated with having the COVID-19 therapeutic drug and the effectiveness or otherwise of the COVID-19 therapeutic drug.
• I understand that I can withdraw consent at any time before the COVID-19 therapeutic drug has been given/administered.

☐ I agree to be contacted by Queensland Health staff after I/the patient received the COVID-19 therapeutic drug, for the purpose of clinical follow-up and potential side effects that will be required to be reported to the Therapeutic Goods Administration (TGA).
   • If yes, please provide your contact number: __________________________
   • If I do not agree to be contacted, this will have no impact at all on any treatment and I/patient will still receive the COVID-19 therapeutic drug.

☐ On the basis of the above statements, I hereby give consent to receive/or the person to receive the recommended doses of the COVID-19 therapeutic drug.

Name of person/substitute decision-maker: __________________________
Signature: __________________________
Date: __________________________

E. Health professional attestation statement (CLINIC USE ONLY)

☐ I have reviewed all allergies, precautions, potential contraindications and other pertinent health information regarding the COVID-19 therapeutic drug and have formed the view it is clinically appropriate for the patient to receive the COVID-19 therapeutic drug.

☐ I have formed the opinion that the person to be treated/substitute decision-maker:
   • has the capacity to consent to receive the COVID-19 therapeutic drug; OR
   • is authorised to consent for the person to receive the COVID-19 therapeutic drug and has the capacity to give this consent (if applicable)
   • has understood the information in the patient information sheet including the risks associated with having the COVID-19 therapeutic drug
   • has been provided with the opportunity to ask me or another health professional any questions relevant to the COVID-19 therapeutic drug
   • gives consent to receive the recommended doses of the COVID-19 therapeutic drug.

Name of clinician: __________________________
Designation: __________________________
Signature: __________________________
Date: __________________________