Queensland Government

COVID-19 Therapeutic Drugs Consent

Adult (18 years and over)

Facility: .....

Medicare number:

Family name:

Given name(s):

Address:

Date of birth: Age: Sex: ☐ M ☐ F ☐ I

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:

v1.00
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DO NOT WRITE IN THIS BINDING MARGIN

COVID-19 THERAPEUTIC DRUGS CONSENT – ADULT