health care professional report (HCPR-F)
CONSENT TO MEDICAL OR DENTAL TREATMENT

how to complete a health care professional report

This report, the Health Care Professional Report-F (HCPR-F) must be completed by a health care professional, a psychologist or a medical practitioner.

Once it is completed, the Guardianship and Administration Board will use this HCPR as evidence in a hearing to determine whether to provide consent to medical or dental treatment.

Generally this report will be required to assist the Board in coming to a conclusion about the person's mental capacity to make relevant decisions.

In circumstances where you have completed a previous HCPR for your client/patient and, in your opinion, there has been no change in your client's/patient's condition you do not need to complete this form again but can certify your opinion in a simple letter to the Board.

completing the report

Please complete the relevant sections of the report. The report will be photocopied for Board members, so please type or print clearly. If space provided in any section of the report is insufficient please type or write on a separate sheet and attach.

Please photocopy the report and keep the copy as your own record.

If you are uncertain about filling in any part of *this form, please contact the Board on 1300 799 625 or (03) 6165 7500 and ask to speak to a Case Assessment Officer.*

payment for health care professional reports

The Board is not responsible for payment for this report. Your fee for this report will be paid from the estate of the person to whom it relates. Please forward the account to the person who requested you to complete the report. The Board considers that a reasonable fee for completing the report is $75.00.

general procedure

The Board will generally accept the HCPR as documentary evidence without the need to call you as a witness. You may be sent a notice inviting you to attend the hearing. You are welcome to come to the hearing. Unless you are specifically notified, you are not required to attend.

In cases where you are required to attend, it is usually possible to attend a hearing by telephone. Please telephone the Board Registry to arrange this.

Please return the report to the person who requested you to complete it.

Telephone: 6165 7500
Fax: 6173 0211
Email: Guardianship@justice.tas.gov.au
Website: www.guardianship.tas.gov.au

Fact Sheets available for download from our website.

1 What is the Guardianship and Administration Board?

2 Guardianship

3 Administration

4 Consent to Medical or Dental Treatment

5 Consent to Medical or Dental Treatment by a Person Responsible

6 Review of Enduring Powers of Attorney

7 Review of Enduring Guardian

8 Statutory Wills

9 Approval of Restrictive Intervention

10 What if I don't agree with the Board's decision?

11 Enduring Guardian Infosheet

12 Sterilisation

health care professional report (HCPR-F)
CONSENT TO MEDICAL OR DENTAL TREATMENT

Application No: ....

health care professional providing this report

Place stamp or fill in details below

Your name ....

Address ....

.... P/Code ....

Preferred Contact Telephone Numbers

....

Fax Number ....

Email address ....

In what capacity do you know the person? (Please tick)

☐ Medical Practitioner ☐ Psychologist

Please note any relevant specialisations ....

the person

Details of the person for whom an application for guardianship and/or administration is being made to the Board.

Name ....

Date of Birth ....

How long have you known the person? ....

On what date did you last personally examine the person?

....

Are you the person's regular medical attendant?

Please tick ☐ Yes ☐ No

Where consent for medical treatment is required for the person, from whom do you obtain that consent?

....

disability of the person

Does the person have a disability/disabilities (please tick)

☐ Yes ☐ No ☐ Unsure

If yes, please specify the type and nature of the disability

(Tick one or more boxes)

☐ Acquired brain injury (resulting from) ....

....

☐ Intellectual disability (give details) ....

....

☐ Psychiatric disability (give details) ....

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☐ Dementia (give details) ....

....

☐ Other (any other details which affects the person's ability to make decisions about personal and/or financial matters) (give details) ....

....

....

....

How long has the disability been evident? ....(years)

Is the disability (please tick)

☐ Static

☐ Deteriorating

☐ Fluctuating

☐ Improving

What is the prognosis? ....

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proposed medical or dental treatment

Describe the medical or dental treatment for which consent is sought.

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effect of disability on the person's circumstances

Does the person experience deficits in particular areas by reason of a disability:

☐ Orientation to person, place or time

☐ Expressive communication

☐ Receptive communication

☐ Impulse control

☐ Capacity for new learning

☐ Susceptibility to influence

☐ Planning and reasoning skills

How does the disability affect the person's ability to make a reasonable decision about the circumstances you have outlined?

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GUARDIANSHIP and ADMINISTRATION BOARD

additional information regarding capacity

Are you aware of any further reports/assessments/examinations e.g. ACAT, neurological or psychiatric assessments which may assist the Board? If Yes, please specify. Please attach medication chart if relevant.

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capacity to give consent to the proposed medical or dental treatment

Can the person understand the nature and effect of the proposed medical or dental treatment?

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Is the person capable of indicating whether or not he or she consents or does not consent to the carrying out of the treatment?

☐ Yes ☐ No

If no, please provide details about how you came to that opinion:

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other observations

Do you have any other observations or comments that may be relevant?

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health care professional report (HCPR-F)
CONSENT TO MEDICAL OR DENTAL TREATMENT

applicant's details

Please give details of the person who is making the application to the Board and/or requested this Health Care Professional Report from you.

Name: ....

Address: ....

.... P/Code..............................

Preferred Contact Telephone Numbers:

....

....

Fax Number ....

Email address ....

Person's attendance at hearing

Does the person have any physical disability that would prevent him or her from attending a Guardianship & Administration Board hearing? (please tick)

☐ Yes ☐ No

If yes, please explain the condition:

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Does the person's mental condition prevent him or her from attending a hearing (please tick)

☐ Yes ☐ No

If Yes, please explain the condition:

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confidentiality

The information in this report may be provided by you without the consent of the person about whom it is written. However, the Board may provide a copy of this report to the person about whom it is written or an "interested party" to the proceedings. If you have any concerns about disclosure of information from the report, please indicate below.

Have you discussed this report with the proposed representative person:

☐ Yes ☐ No

Do you have concerns about disclosing the contents of this report to the person about whom it is written or any "interested party" (please tick)

☐ Yes ☐ No

If yes, please provide details:

....

....

....

....

I have provided this report in good faith and have reasonable and probably grounds for believing the report to be true.

Practitioner's Signature: ....

Dated: ....

Would you like to receive a hearing notice in respect of this matter:

☐ Yes ☐ No

Office Use Only

Send hearing notice: ☐ Yes ☐ No
Date report received:
Date data entered:
Attach to Application No:
Attach to Matter No: