# health care professional report (HCPR-G)
# CONSENT TO STERILISATIONS

## how to complete a health care professional report

This report, the Health Care Professional Report (HCPR) 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 and whether the proposed treatment is in the best interests of the person.

## 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 an Investigator.

## 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 treatment

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. Staff members of the Board will discuss this with you before the hearing. Please return the report to the person who requested you to complete it.

Alternatively, you may forward it directly to the Board, addressed as follows:

The Registrar
Guardianship and Administration Board
GPO Box 1307
HOBART
Tasmania 7001

OR you may deliver the completed report to the Registrar at the Board's offices at:

Level 2, 144 Macquarie Street
HOBART

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.

# health care professional report (HCPR-G)
# CONSENT TO STERILISATIONS

Application No. _____ Date: _____

## name and position of healthcare professional providing this report

please stamp or fill in details below

First Name _____ Last Name _____

Position _____

In what capacity do you know the person _____

How long have you known the person _____

How many times has the person consulted you _____

Date of last personal examination _____

Are you aware of person's medical history? _____

## the person

Name, gender and date of birth of person to whom application relates.

First Name _____ Last Name _____

Gender (Please tick) ☐ Male ☐ Female

Date of Birth _____ /_____ /_____

## disability of the person

Attach any relevant supporting documents for evidence of disability and the contact details of those relevant practitioners.

Describe the person's disability

How long has the disability been evident _____

Is the disability static, deteriorating, fluctuating or improving?

Please provide details of the diagnosis and history of the person's disability and its effect on decision making

# health care professional report (HCPR-G)
# CONSENT TO STERILISATIONS

## proposed medical or dental treatment

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

## 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

## 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.

## 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?:

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 - please provide details about how you came to that opinion:

## other observations

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

## medical needs of person

Attach any relevant supporting documents in relation to the person's medical condition and the contact details of those relevant practitioners

What is the person's medical condition/s? Is the person's condition stable? (Include any relevant information about reproductive health of the person, including any difficulties in relation to menstruation and gender reassignment)

Are there any specific medical problems relating to being on long-term hormonal contraceptive medication?

Are there any medical or disability-related problems that could make you consider that pregnancy, labour and post-pregnancy states would be associated with serious medical illness or be life threatening?

If surgery is contemplated, are there particular peri-operative medical problems associated with the operation?

Would the patient have any risks being an inpatient in the hospital setting and how would these be addressed?

Is the patient's home situation such that any post-discharge surgical routine care or complications would be able to be monitored and addressed?

Do you think that the patient would benefit medically by having successful sterilisation?

## proposed treatment

Attach any relevant supporting documents in relation to the proposed treatment and the contact details of those relevant practitioners

Explain the proposed treatment which is intended or reasonably likely to have the effect of rendering the person permanently infertile.

Are there less restrictive treatments or alternative treatments that have been attempted, or considered, that would not render the person infertile? Would alternative or less invasive treatment be more appropriate to promote and maintain the person's health and wellbeing?

What are the risks and complications associated with the proposed treatment?

What are the risks for the person's health, personal and social wellbeing if the proposed treatment does not proceed?

What would be the impact on the person's life in general, and their family and/or carers if the proposed treatment does, or does not, proceed?

## wishes of person

Describe what the person has communicated to you

Is there any relevant past conduct that has made the person's attitude to this treatment clear?

Are there any documents such as an advance care plan, an enduring guardianship/attorney

instrument or other documents which may indicate the person's attitude to this treatment?

## wishes of other relevant parties

Are there other interested parties who have views about the proposed treatment? If so, please explain those views

## information about alternatives

Have you discussed in detail the less invasive medical alternatives to sterilisation with a medical practitioner?

please tick ☐ Yes ☐ No

who? _____

If you are aware of the alternatives, which have been attempted with the patient and what has been the effect on the person?

1. _____

2. _____

3. _____

4. _____

5. _____

If you are aware of the alternatives and they have not been attempted, why have they not been attempted?

# health care professional report (HCPR-G)
# CONSENT TO STERILISATIONS

## name of applicant

Name _____

## person's attendance at hearing

Will the person be attending the hearing? If no, please provide details why

☐ Yes ☐ No ☐ Other

## 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 or Tribunal 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 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'?

☐ Yes ☐ No

Please explain any concerns

## signature and acknowledgment

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

First Name _____ Last Name _____

Phone no _____

Address _____

Type of healthcare professional _____

Signature _____

Date _____ / _____ / _____

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

☐ Yes ☐ No

*Office Use Only*

Date report received:

Date data entered:

Attach to Application No.