Alberta Health Services

Community Treatment Decisions Consent
(on Behalf of a Person subject to a Community Treatment Order “CTO”)

Client Last Name	First Name	Personal Health Number/ULI
Date of Birth *(yyyy-Mon-dd)*	Address	
City/Town	Postal Code	Phone

Verification of Legal Authority- Confirm copy of Personal Directive or Guardianship/Custody/other applicable Court Order has been obtained and is present on the patient health record.

Declaration

I, *(name of Guardian/Parent/Agent/Relative)* ____, certify as follows:

1. I understand and believe that *(name of Client)* ___________________________ is a person subject to a CTO (the “Client”) under the Alberta Mental Health Act and is a minor or is not mentally competent to make treatment decisions.
2. I am the Client’s ☐ Guardian
   ☐ Parent
   ☐ Agent
   ☐ Nearest Relative (as defined in S.28 MHA)*(describe)*______________________________

   I have been in personal contact with the Client over the past 12 months and I am mentally competent and willing to assume responsibility for making treatment decisions on the Client’s behalf.
3. I have been advised of and understand the nature of the illness for which the diagnostic procedure and/or treatment is proposed.
4. I have been advised of and understand the diagnostic procedure and/or the proposed treatment.
5. I have been advised of and appreciate the consequences to the Client if I give or withhold this consent.
6. I make these treatment decisions in accordance with what I believe to be in the best interest of the Client having regard to the following:
   a. whether or not the mental condition of the Client will be or is likely to be improved with the treatment,
   b. whether the Client’s condition will deteriorate or is likely to deteriorate without the treatment,
   c. whether or not the anticipated benefit from the treatment outweighs the risk of harm to the Client, and
   d. whether or not the treatment is the least restrictive and least intrusive treatment that meets the criteria in a, b, and c above.

Authorization for Treatment & Diagnostic Procedures:

1) I hereby consent to Dr. _________________________ or whomever he/she may designate to provide the following treatments for the duration of the Client’s Community Treatment Order :

   A. Psychiatric examinations and diagnostic tests,

   B. All usual psychiatric interventions used in the diagnosis of mental disorders,

   C. Medications of the following general description:

   ____

   ____

   D. Other procedures as explained to me:

   ____

   ____

continued on Page 2

Alberta Health Services

Client Name *(last, first)*
Birthdate *(dd-Mon-yyyy)*
PHN#/ULI

Community Treatment Decisions Consent

Authorization for Treatment and Diagnostic Procedures, continued

2) Explanation of the anticipated effect, nature, purpose, expected benefit, and degree of seriousness of the previously listed treatment(s) and diagnostic procedure(s) has been given to me and I am aware of and fully understand the potential discomforts, material and probable risks, possible risks with grave consequences and special and unusual risks inherent in the above procedure(s)/treatment(s). In the event that an anaesthetic or analgesic is required for any of the above listed treatments or procedures, I consent to the administration of an anaesthetic or analgesic by a qualified physician.
3) Further, I understand that during the course of the procedure(s)/treatment(s), unforeseen conditions may necessitate alternative procedure(s).
4) I have been informed of any reasonable alternatives to the above procedure(s)/treatment(s). I have been given the opportunity to ask questions and those questions have been answered to my satisfaction.
5) I understand that I am free to withdraw this consent at any time prior to or during the procedure(s)/treatment(s).

I hereby declare and consent, as outlined above and on Page 1 of this document:

Name of Guardian/Parent/Agent/Relative *(print)*	Signature	Date *(yyyy-Mon-dd)*	Time
Name of Witness *(print)*	Signature	Date *(yyyy-Mon-dd)*	Time

Physician Statement

I have reviewed and explained to the person providing consent that he/she understands the contents of the above document and has signed above. An offer to answer any questions was made.

Name of Physician *(print)*	Signature	Date *(yyyy-Mon-dd)*	Time

If the consenting person is unavailable to sign the original, you may collect consent by telephone or fax. It is advisable to collect an original signature at the earliest opportunity. Page 1 must still be completed.

☐ **Telephone Consent** Where possible a witness should be used.

☐ **Obtaining Faxed Consent**

Telephone/fax consent has been obtained from ____

Name *(print)* of staff member	Signature	Date *(yyyy-Mon-dd)*	Time
Name *(print)* of witness (if available)	Signature	Date *(yyyy-Mon-dd)*	Time

Obtaining Consent of a Non-English Speaking Patient

I acknowledge that I have interpreted the contents of this Consent to the person consenting and I believe that the person consenting understands the contents.

Name of Interpreter *(print)*	Signature of Interpreter	Date *(yyyy-Mon-dd)*	Time