Name: _____ DOB ___ / ___ / ___

INFORMED, VOLUNTARY CONSENT CHECKLIST AND SAMPLE QUESTIONS[a]

Inform the patient that you will be doing a capacity assessment with him/her. Do not assume that the patient will understand the connection between the illness and some consequent intervention.
Use the categories below to guide your assessment, and the examples below them if helpful.

- For each category of question, check **Yes**, **No** or **Unsure**.
- If the answer is No to any of these questions, the patient is not capable.

1. Does the patient understand that you are offering an intervention for a health problem?

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g., What problems are you having right now?
What problem is bothering you most?
Do you know why you are in the hospital/clinic?

2. Does the patient understand the nature of the proposed investigation or treatment and the expected benefits, burdens, and risks?

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g., What could be done to help you with your (specify health problem)?
Do you think you are able to have this treatment?
Do you know what might happen to you if you have this treatment?
Do you know if this treatment can cause problems? Can it help you live longer?

3. Does the patient understand possible alternative treatment options and their expected benefits, burdens, and risks?

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g., Do you know different ways that might make you feel better?

4. Does the patient understand the likely effects of not having the proposed investigation or treatment?

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g., Do you know what could happen to you if you don't have this (*specify*) done?
Could you get sicker or die if you don't have this (*specify treatment*)?
Do you know what could happen if you have this (*specify treatment*)?

5. Is the patient free from any duress (e.g., illness, family pressure) or pain or distress that might impair his/her capacity regarding the particular decision? (Note that a relatively minor illness can cause significant anxiety.)

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g.,Can you help me understand why you've decided to accept/refuse this treatment?
Do you feel that you're being punished?
Do you think you're a bad person?
Is anyone telling you that you should or should not get this treatment?

6. Is the patient free from a mental health condition (e.g., mood disturbance or psychiatric illness) that may influence his/her capacity to give consent? (Note that having mental illness is not in itself an indicator of incapacity. This factor may change once the mental health condition is treated.)

☐ **Yes** ☐ **No** ☐ **Unsure**

e.g., Are you hopeful about the future?
Do you think you deserve to be treated?
Do you think anyone is trying to hurt and/or harm you?
Do you trust your doctor and nurse?

CAPABLE	NOT CAPABLE	UNSURE
If "YES" to ALL of the above, and the patient can remember the information long enough to make a decision (verify by asking him/ her to explain the information to you), then consider that capacity exists to consent to or refuse the proposed treatment.	**If "NO" to ANY of the above**, then repeat the questions; you may need to repeat this process several times to ensure that the patient understands. **If the patient still does not understand**, he/she is incapable and a legal Surrogate Decision Maker (SDM) should be assigned.	**Consult family, if you have not already done so. Consider seeking a second opinion from**: • A **second physician** who is not directly involved in the patient's health care. • Your **facility's ethics mechanism** if available.

[a]Questions adapted from: Etchells E. Joint Centre for Bioethics-Aid to Capacity Evaluation **www.utoronto.ca/jcb**

INFORMED, VOLUNTARY CONSENT CHECKLIST AND SAMPLE QUESTIONS[a]

Name: _____ DOB ___ / ___ / ___

ASSESSMENT

Date: ___/___/___ **Print Name:** _____ **Signature:** _____