Saskatchewan Health Authority

COVID-19 Pandemic
COVID-19 Vaccine Consent WITHOUT Capacity or Substitute Decision Maker

INITIAL APPLICABLE BOXES

This form is to be used only for persons who DO NOT HAVE:

- **capacity to make health care decisions, AND**
- **a health care directive, proxy, personal guardian or nearest relative (collectively – substitute decision maker or SDM) to provide consent.**

Section 1: Client Information OR see addressograph/label above

Last Name	First Name	Gender M F
Health Services Number	Birthdate (MM/DD/YY)	Long Term Care or Personal Care Home (if applicable)

Section 2: Vaccine Screening Questions and Vaccine Consent:
(TWO Designated Treatment Providers* to complete)

☐ This person has been reviewed by their primary health care practitioner and has no contraindications to receiving the COVID-19 vaccine (documentation** of same is in the person's health record/medical file).

☐ COVID-19 Screening Questions completed – Vaccine Type: _____

Refer to ***saskatchewan.ca/COVID19*** for more information.

1. Does this person have severe allergies? ☐ No ☐ Yes – describe: _____
2. Has this person reacted to previous vaccines? ☐ No ☐ Yes – describe: _____
3. Is this person immune compromised or have an autoimmune condition? ☐ No ☐ Yes _____
4. Is this person on any medication? ☐ No ☐ Yes – list _____
5. Has this person received previous vaccines in the last 14 days? ☐ No ☐ Yes _____
6. Does this person have any bleeding disorders? ☐ No ☐ Yes – describe: _____

Based on the person's available health information, I have completed/reviewed the questions above, believe vaccinating the person will help prevent serious illness or death from COVID-19 disease, have assessed the risks accordingly, and confirmed the person's eligibility for the COVID-19 vaccine. I state the following:

1. The person's consent to COVID-19 immunization is unable to be obtained because of incapacity of the person.
2. Efforts to determine and/or locate a substitute decision to provide consent for the person to receive COVID-19 immunization have been unsuccessful.
3. The person has not, to my knowledge, refused to consent to the purposed COVID-19 immunization.

Designated Treatment Provider(s) to indicate what efforts were made to obtain valid consent and why unobtainable:

Name of First Designated Treatment Provider*	Name of Second Designated Treatment Provider*
Signature of First Designated Treatment Provider	Signature of Second Designated Treatment Provider
Date (MM/DD/YY):	Date (MM/DD/YY):

*If two nurses, one of the Designated Treatment Providers must be a registered nurse in a Public Health Nurse role.

**Documentation can be direct from primary physician or telephone conversation between primary physician and Designated Treatment Providers.