MEDICAL REPORT TEMPLATE
AGED CARE RESTRICTIVE PRACTICES
SUBSTITUTE DECISION-MAKER ACT

VCAT
Victorian Civil & Administrative Tribunal

ABOUT VCAT

The Victorian Civil and Administrative Tribunal (VCAT) resolves disputes and makes decisions. VCAT's Guardianship List of the Human Rights Division hears applications about restrictive practices substitute decision makers. VCAT can appoint a restrictive practices substitute decision-maker or make orders about decision-making capacity. We can also make orders regarding the validity of a nomination or a revocation of a restrictive practices nominee, the appointment of a substitute decision maker, and the revocation of a VCAT appointment of a substitute decision-maker. We can also act as the decision-maker of last resort and consent to the use of restrictive practices, where no one else can be identified as a substitute decision-maker.
Visit www.vcat.vic.gov.au/AgedCareTemplate for more information.
For help completing this report, email humanrights@courts.vic.gov.au.

WHY WE NEED A MEDICAL REPORT

We need a medical report as evidence from a medical practitioner about a care recipient's decision-making capacity. The report needs to cover whether a care recipient does or does not have decision-making capacity about nominating a restrictive practices substitute decision-maker or to consent to the restrictive practice proposed. The report also needs to specify what the proposed restrictive practice is and indicate whether less intrusive options have been considered by the aged care provider. As a medical practitioner, the information you provide is vital. Your report will allow VCAT to determine issues that are critical to whether VCAT should make an order that will protect the rights, life, health, safety, preferences and values, or personal well-being of vulnerable people. This form is offered to practitioners to ensure the process of providing a medical report is as streamlined and as simple as possible. A medical report may be provided in another format if the practitioner wishes. However, the criteria provided in this form must be sufficiently addressed to enable us to make the assessment described above.

AUTHORITY FOR REQUEST AND IMMUNITY

VCAT has the authority to request this information under the *Victorian Civil and Administrative Tribunal Act 1998* (VCAT Act) including Clause 4AAE of Schedule 1. We appreciate the assistance of practitioners in providing this essential service to vulnerable Victorians and the broader Victorian community. By providing VCAT a medical report, a medical practitioner is taken to be giving evidence as a witness within the meaning of s 143(4) of the VCAT Act. This section provides that a person appearing as a witness before VCAT has the same protection and immunity as a witness has in proceedings in the Supreme Court. This immunity refers to the protection of an expert witness from legal action being taken against them for any evidence they give to a court. This immunity extends to any statement which the expert witness gives for the purpose of giving evidence, including evidence given in a report.

COSTS INCURRED BY PRACTITIONERS

We do not provide payment for medical reports. If practitioners intend to charge a private fee for the service, the account should be sent to the person or their administrator, attorney, or family member.

ASSESSING DECISION-MAKING CAPACITY

A medical professional assessing decision making capacity must take reasonable steps to conduct the assessment at a time and in an environment where the care recipient's decision-making capacity can be assessed most accurately.

CARE RECIPIENT'S DETAILS

1. Enter the details of the care recipient you are completing this medical report about.

Title | Given name | Last name

Aged care recipient's date of birth (DD/MM/YYYY): / /

VCAT reference number (if known)

Residential aged care facility address

Suburb | State VIC | Postcode

2. In what capacity do you know the care recipient?

☐ General practitioner

☐ Specialist, please specify

☐ Other, please specify

3. Are you the care recipient's regular medical practitioner?

☐ Yes, skip to Question 5 ☐ No

4. Provide contact details of the care recipient's regular medical practitioner (if known)

Name of regular medical practitioner

Email

Phone number

5.How long have you been the care recipient's medical practitioner?

years months

6.Details about the last time you saw the care recipient

☐ I saw the care recipient in person ☐ I saw the care recipient but not in person

Date you last saw the care recipient (DD/MM/YYYY): / /

7.Is the care recipients usually accompanied by someone else when you see them?

☐ Yes, provide details below ☐ No

Who are they usually accompanied by when you see them?

CARE RECIPIENT'S DECISION-MAKING CAPACITY

8. Does the care recipient have any medical conditions which could affect their decision-making capacity?

☐ Yes ☐ No

9. Provide details of the diagnosis and history of the care recipient's medical condition and a copy of any relevant medical reports from other medical practitioners.

You must also include details and dates of any tests, examinations or assessments performed by you or others, including other medical practitioners or neuropsychologists.

10. What is the status of the care recipient's medical condition?

☐ Permanent ☐ Progressive ☐ Fluctuating ☐ Improving

PROPOSED RESTRICTIVE PRACTICES

11. What is the restrictive practice proposed by the approved provider?

☐ Physical restraint ☐ Mechanical restraint ☐ Environmental restraint (e.g. locked doors)
☐ Chemical restraint (e.g. psychotropic medication for behavioural control) ☐ Seclusion
☐ Other – please describe:

12. Have other less intrusive strategies or interventions been tried?

☐ Yes, provide details of the strategies or interventions tried: ☐ No, skip to Question 14

13. Explain why the less intrusive strategies / interventions mentioned above were found not to be effective?

14. Explain why other less intrusive strategies / interventions were not tried?

15. Is the proposed restrictive practice included in a current Behavioural Support Plan (BSP)?

☐ Yes ☐ No ☐ Don't know

CURRENT DECISION-MAKING CAPACITY OF THE CARE RECIPIENT

16. In your professional opinion, does the care recipient currently have decision-making capacity to consent to use of the proposed restrictive practices?

For them to have the capacity to consent to use of the proposed restrictive practices, they must be able to:

- understand the information relevant to the decision and the effect of the decision; and
- retain that information to the extent necessary to make the decision; and
- use or weigh that information as part of their decision-making process; and
- communicate the information to make a decision and to express their views and needs.

☐ **Yes,** I confirm **the care recipient has decision-making capacity** to consent to the use of the proposed restrictive practices

☐ **No,** because due to their medical condition or disability, **the care recipient cannot do one or more of the above**

17. Explain how you formed your opinion about the care recipient's decision-making capacity. For example tests, assessments and other medical practitioners' opinions.

18. Provide details and dates of any tests, examinations or assessments to support your opinion

RESTRICTIVE PRACTICES NOMINEE

19. Has the care recipient nominated a restrictive practices nominee?

☐ Yes ☐ No, skip to Question 23 ☐ Don't know, skip to Question 23

20. When was the restrictive practices nominee nominated?

Date of nomination (DD/MM/YYYY): / /

21. Did you know the care recipient at the time?

☐ Yes ☐ No, skip to Question 23

22. Did the care recipient have capacity to nominate a restrictive practices nominee at the time?

☐ Yes, provide details below ☐ No ☐ Don't know

Provide details about their decision-making capacity at the time, below

NOMINATION OR REVOCATION OF A RESTRICTIVE PRACTICES NOMINEE

23. Does the care recipient currently have decision-making capacity to nominate or to revoke the nomination of a restrictive practices nominee?

For them to have the capacity to consent to nominate or to revoke the nomination of a restrictive practices nominee, they must be able to:

- understand the information relevant to the decision and the effect of the decision; and
- retain that information to the extent necessary to make the decision; and
- use or weigh that information as part of their decision-making process; and
- communicate the information to make a decision and to express their views and needs.

☐ **Yes,** I confirm **the care recipient has decision-making capacity** to nominate or to revoke the nomination of a restrictive practices nominee

☐ **No,** because due to their medical condition or disability, **the care recipient cannot do one or more of the above**

24. Explain how you formed your opinion about the care recipient's decision-making capacity. For example tests, assessments and other medical practitioners' opinions.

25. Provide details and dates of any tests, examinations or assessments to support your opinion

OTHER FACTORS THAT MAY AFFECT DECISION MAKING

26. In your professional opinion, if there are any other factors that could potentially impact the care recipient's decision-making capacity, please list them below and provide details.

For example, vulnerability to influence from others

CARE RECIPIENT'S PARTICIPATION IN THE HEARING

27. Based on your professional assessment of the care recipient's condition, would they be able to attend a VCAT hearing either in person, by video link or by phone?
Answer 'Yes' if they can attend by themselves or assisted by another person

☐ Yes, state how they can attend in Question 28 ☐ No, state reasons for this opinion in Question 28

28. If they can attend, let us know how they can attend (in person, video link or by phone). If they cannot attend, let us know your reasons for this opinion.

29. Does the care recipient need an interpreter?

☐ Yes, specify language or dialect below ☐ No

30. Does the care recipient have difficulty communicating?

☐ Yes, provide details below ☐ No

MEDICAL PRACTITIONER'S DETAILS

31. Provide your details below

Title | Given name | Last name

Your qualification

Your provider number

Name of clinic

Name of organisation or aged care facility

Street address

Suburb | State VIC | Postcode

Email

Phone number

We might need to contact you during or prior to the care recipient's VCAT hearing for more information.

ACKNOWLEDGMENT

By completing this application, I understand and acknowledge that:

☐ to the best of my knowledge, all information provided in this application is true and correct

☐ it is an offence under section 136 of the *Victorian Civil and Administrative Tribunal Act 1998* tp knowingly give false or misleading information to VCAT

Signature

Date (DD/MM/YYYY): / /

PRIVACY INFORMATION

Our privacy statement is available at **www.vcat.vic.gov.au/Privacy**

SUBMITTING THIS REPORT

Thank you for your time in completing this document. VCAT appreciates this community service.

Need help completing this report? Email humarights@courts.vic.gov.au or call 1300 018 228.

Please submit this completed report with all questions answered to VCAT either by email or by post.

By email

Email
humanrights@courts.vic.gov.au

In person

Go to:
VCAT
Level 4, 414 La Trobe St,
Melbourne VIC 3000

By post

Send to:

Human Rights Registrar
GPO Box 5408
Melbourne VIC 3001