

CONSENT FOR COVID-19 SWAB TESTING FOR PERSONS LACKING CAPACITY TO CONSENT

Client Details

Name

Surname

ID number

Date of birth

Date, time,
and place of
appointment

The above mentioned client is unable to comprehend and retain information related to the decision and its implications and/or unable to use and weigh this information in a decision-making process and therefore cannot give a verbal consent for the COVID19 swabbing test.

Involvement of client's relatives / medical procurator/responsible carer

I understand that the client is unable to give his/her verbal consent, and that the test will be performed because it is in the best interests of the client, and that I myself will be consenting on his/her behalf for the COVID19 swabbing test to be performed

The test has been explained to me, and I have been informed of the **purpose** and reasonable expected **benefits** of this test.

I understand that all tests involve **risks**, including the possibility of pain, bleeding, headaches, and broken swabs that remain lodged in the nasopharynx requiring further medical assistance. I have been informed of the general risks of the test as well as those specific to the client.

I have been given the opportunity to ask **questions**.

I am aware that the person/s accompanying the client may be required to assist the healthcare worker in taking the swab.

Signature of medical procurator/ next of kin/responsible carer

Full Name and Surname (block letters)

ID no. of signatory

Relationship to client

Date