Place Patient Form Label Here

IDENTIFICATION OF SUBSTITUTE DECISION MAKER (PHC)

* 2 7 6 0 *

Consent Other

Complete this form to confirm identification of the person appointed to make substitute consent decisions. If the patient has not identified a Prearranged Substitute Decision Maker, a Temporary Substitute Decision Maker will need to be appointed.

Confirmation of Prearranged Substitute Decision Maker

I am authorized to make the consent/refusal decision described the accompanying consent form in my capacity as:

- ☐ Committee of Person (provide copy of court order to health care provider as soon as time permits)
- ☐ Representative with authority to make this decision (provide copy of agreement to health care provider as soon as time permits)
  - ☐ section 7
  - ☐ section 9

Name of Substitute Decision Maker	X Signature of Health Care Provider	Date	Phone # For SDM

Appointment of Temporary Substitute Decision Maker (TSDM)

I qualify to be chosen as the Temporary Substitute Decision Maker because I am (choose the person who ranks highest on the following list):

- ☐ the adult's spouse (includes common-law or same-sex partner in a marriage-like relationship)
- ☐ the adult's child
- ☐ the adult's parent
- ☐ the adult's brother or sister
- ☐ the adult's grandparent
- ☐ the adult's grandchild
- ☐ anyone else related by birth or adoption to the adult
- ☐ a close friend of the adult
- ☐ a person immediately related to the adult by marriage
- ☐ in the absence of any of the above, someone authorized by the Public Guardian & Trustee *(see over)*

I confirm that I:

- am at least 19 years of age,
- have been in contact with the patient during the last 12 months,
- have no dispute with the patient,
- am capable of giving, refusing or revoking substitute consent, and
- am willing to comply with the duties in section 19 of the *Health Care (Consent) and Care Facility (Admission) Act:*
  - I will consult as much as possible with the adult, and if I have been authorized by the Public Guardian & Trustee with any friend or relative of the adult who asks to assist,
  - I will comply with any instructions or wishes the adult expressed while he/she was capable, and
  - If the adult's instructions or wishes are not known, I will give or refuse consent based on the adult's known beliefs and values, or in the adult's best wishes if his/her beliefs and values are not known.

When deciding if it is in the adult's best interest to give, refuse or revoke substitute consent I understand that I must consider each of the following:

- the adult's current wishes
- whether the adult's condition or well-being is likely to improve with or without the proposed health care
- whether the benefit the adult is expected to get from the proposed health care is greater than the risk of harm
- whether a less restrictive or intrusive form of health care would be as beneficial as the proposed health care

Temporary Substitute Decision Maker

I have read and understood the statements and responsibilities above that apply to TSDM's and confirm that I am willing and able to act as this adult's TSDM.

X Signature of Temporary Substitute Decision Maker	PRINT NAME	Date	Phone

Health Care Provider

To the best of my knowledge the person named above is the appropriate individual to make health care decisions on this patient's behalf.

X Signature of Health Care Provider	PRINT NAME / TITLE	Date & time of signature

REFERRAL TO PUBLIC GUARDIAN AND TRUSTEE FOR A TEMPORARY SUBSTITUTE DECISION MAKER (PHC)

* 2 7 6 0 *

Consent Other

Place Patient Form Label Here

Complete this form and fax to Public Guardian & Trustee at 604-660-9498 to arrange a TSDM

Re: _____
(patient name)

This patient is receiving, or it has been determined that he/she requires, health care in our facility. He/she is not capable of providing consent for treatment as defined under Section 7 of the *Health Care (Consent) and Care Facility Act* and does not have a Committee of Person or a Representation Agreement designating a health care decision maker.

The above named patient does not have a qualified Temporary Substitute Decision Maker because:

☐ He/she has no nearest relative readily accessible or willing to act as TSDM

OR

☐ He/she has one or more near relatives but all are disqualified:

- ☐ is/are under 19 years of age
- ☐ has/have not been in contact with the adult during the preceding 12 months
- ☐ has/have a dispute with the adult relevant to this decision
- ☐ is/are not capable of giving, refusing or revoking substitute consent
- ☐ is/are not willing to comply with the duties demanded by this role

OR

☐ There is a dispute among near relatives about who is to be chosen.

In the opinion of the undersigned health care provider:

☐ There is **NO** friend or other person close to the adult who would be appropriate to act as a TSDM

OR

☐ There **IS** a friend or other person close to the adult who would be appropriate to act as a TSDM

Name: _____ Relationship: _____

Phone: _____ Address: _____

A temporary substitute decision maker is needed to make a decision on the following proposed care:

_____

Care Provider making referral: (name) _____

Telephone: _____ Fax: _____