

I N S T R U C T I O N S

This form must be filled out by a health care provider. Copies of this form must be provided to the:

- Public Guardian and Trustee; and
- care recipient.

Re: _____
Print full name

of _____
Home address

currently residing at _____,
Name of facility or other current place of residence

health insurance number _____, telephone number _____.

I, _____
Print name of health care provider

of _____ state that:
Print name of medical clinic or health care facility

1. On _____ I determined that the above-named person is incapable of giving or
Date (day/month/year) refusing consent to a care decision regarding _____
Care decision or treatment decision found incapable of making

2. I observed the following facts indicating incapability to give or refuse consent to the above-named decision (i.e., unable to understand and appreciate the likely consequences of the decision and that it applies to their own situation).

3. The following facts, if any, indicating incapability to consent to the care decision, were communicated to me by others. (*State facts and source of information.*)

4. I understand that the above-named person is required to make the following financial decisions.

- | | | |
|--|---|--|
| <input type="checkbox"/> pay bills | <input type="checkbox"/> manage investments | <input type="checkbox"/> handle large sums |
| <input type="checkbox"/> pay debts | <input type="checkbox"/> do income tax return | <input type="checkbox"/> balance accounts |
| <input type="checkbox"/> handle small currency | <input type="checkbox"/> pay monthly rent or mortgage | <input type="checkbox"/> make tax payments |
| <input type="checkbox"/> manage a business | <input type="checkbox"/> write cheques | <input type="checkbox"/> other _____ |

5. I observed the following facts indicating incapability to make reasonable judgements or decisions regarding the above financial decisions (i.e., unable to understand and appreciate the likely consequences of their financial decisions and/or unable to carry out decisions).

6. The following facts, if any, indicating incapability to make reasonable financial judgements or decisions were communicated to me by others. *(State facts and source of information.)*

7. Please provide any details of the person's estate that you are aware of (e.g., bank accounts, bills) that will be relevant to the management of the person's estate.

8. Contact information for the substitute decision-maker or other family member or friend who may be able to supply information on the person's financial affairs to the public guardian and trustee:

Print full name of contact person

_____ Address _____ Phone number

9. I believe on reasonable grounds, that because of a health condition, namely,

_____, the above-named person is incapable of making reasonable decisions regarding their financial affairs for these reasons:

Multiple horizontal lines for providing reasons.

DATED at _____,
this _____ day of _____ month, _____ year.

} _____ SIGNATURE OF HEALTH CARE PROVIDER
} _____ PRINTED NAME OF HEALTH CARE PROVIDER

_____ SIGNATURE OF WITNESS

Information on this form is being collected, pursuant to the Care Consent Act, to meet the requirements for a valid Certificate of Need for Financial Protection. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse Yukon Y1A 2C6, (867) 667-5919.