Ontario

Consent and Capacity Board

Form D - Application to the Board for Directions under Subsection 35(1), 52(1) or 67(1) of the *Health Care Consent Act.*

Section 1 - Applicant

Last Name	First Name		
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address	

Section 2 - Applicant Type

I apply to the Board for direction to the Patient/Resident's Substitute Decision Maker.

☐ I am the Patient/Resident's Substitute Decision Maker.

Note: Persons in the following categories may only bring an application if they have given prior notice to the Substitute Decision Maker of their intention to do so.

☐ I am the health practitioner who proposed the treatment for the Patient / Resident

☐ I am the official of the LHIN responsible for authorizing admission of the Patient / Resident to a Long Term Care Home

☐ I am the service provider responsible for providing personal assistance services to the Patient / Resident

Section 3 - Patient/Resident

Last Name	First Name		
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address	

Section 4 - Patient/Resident Prior Wishes

Patient/Resident above has previously expressed a wish with respect to this matter but (mark as many as are applicable):

☐ the wish is not clear.

☐ it is not clear if the wish is applicable in the circumstances.

☐ it is not clear if the wish was expressed when the person was capable.

☐ it is not clear if the wish was expressed after the person attained sixteen years of age.

Section 5 - Finding of Incapacity

The Patient/Resident has been found incapable with respect to:

☐ Consenting to their treatment

Specify:

☐ Consenting to their admission to a Long Term Care Home

☐ Consenting to receiving personal assistance services in a Long Term Care or Retirement Home

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Section 6 - Person Who Made the Finding of Incapacity

Note: An application may only be made if a health practitioner or evaluator has made a relevant finding of incapacity.

Last Name			First Name	
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number		Email Address	

Section 7 - Patient/Resident's Substitute Decision Maker

Last Name			First Name	
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number		Email Address	

Section 8 - Health Practitioner Who Proposed the Treatment

If this application refers to **treatment**, provide the contact information about the person proposing treatment.

☐Same as Section 6

Last Name			First Name	
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number		Email Address	

Section 9 - Person Responsible for Authorizing Admission to Long-Term Care

If this application refers to **admission to long term care**, provide the contact information about the person responsible for authorizing admission to the facility. This will usually be a person from the Local Health Integration Network.

☐Same as Section 6

Last Name			First Name	
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number		Email Address	

Section 10 - Person Responsible for Providing a Personal Assistance Service

If this application refers to a **personal assistance service**. This may be the person or organization that provides the service.

☐Same as Section 6

Last Name			First Name	
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code

Telephone No. (including area code)	Fax Number	Email Address

Section 11 - Information About the Facility

Is the Patient/Resident currently an in-patient or resident at a health or residential facility

☐Yes, provide information about the facility ☐No

Name of Facility			Ward
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Contact Name (First Name, Last Name)	Telephone No. (including area code)		Fax Number

Section 12 - Person Who Will Represent the Applicant at the Hearing (e.g. lawyer)

Last Name		First Name	
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address	

Section 13 - Person Who Will Represent the Substitute Decision Maker at the Hearing (e.g. lawyer)

Last Name		First Name	
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address	

Section 14 - Other Information That Will Assist Us in Arranging the Hearing

Interpreter Required

☐Yes ☐No

Language

Accommodation required

☐Yes ☐No

Specify

Other Information

Date of Application (yyyy/mm/dd)

Collection of this information is for the purpose of conducting a proceeding before this Board. It is collected/used for this purpose under the authority of subsection 35(1) / 52(1) / 67(1) of the *Health Care Consent Act*. For information about collection practices, contact the Board. Fax completed application to the Board at 1-866-777-7273 or send by email to ccb@ontario.ca.