Ontario

Consent and Capacity Board

Form G - Application to the Board to Determine Compliance under Subsection 37(1), 54(1) or 69(1) of the *Health Care Consent Act.*

Section 1 - Applicant

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

Section 2 - Applicant Type

I apply to the Board for a determination as to whether or not the Substitute Decision Maker in this case has complied with the principles for substitute decision-making as they are set out in the Act.

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

Section 4 - 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

Section 5 - 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 No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code
Telephone No. (including area code)	Fax No.	Email Address	

Section 6 - Patient/Resident's Substitute Decision Maker

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

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

Section 7 - Health Practitioner Who Proposed the Treatment

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

☐Same as Section 5

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

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

Section 8 - 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 admissions to the facility. This will usually be a person from the Local Health Integration Network.

☐Same as Section 5

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

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

Section 9 - 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 5

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

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

Section 10 - Facility

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

○No ○Yes, provide information about the facility

Name of Facility	Ward

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code
Contact Name (First Name, Last Name)	Telephone No. (including area code)	Fax No.

Section 11 - Person Who Will Represent the Applicant at the Hearing (e.g. lawyer)

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

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

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

Section 13 - 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 37(1) / 54(1) / 69(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.
For assistance, call: 1-866-777-7391.