PUBLIC GUARDIAN AND TRUSTEE OF BRITISH COLUMBIA

REFERRAL FORM
Services to Adults

The information on this form is collected under the authority of the *Public Guardian and Trustee Act*. Information collected may be used for the purpose of authorizing the Public Guardian and Trustee to act as Committee of Estate through Certificate or Court Order under the *Patient's Property Act*. If you have questions about the collection and use of this information, please contact Assessment & Investigation Services.

Referral Criteria:
It is appropriate to refer an individual (over the age of 19 years) to the Public Guardian and Trustee of British Columbia if there is:

a) a concern about the individual's mental capability to manage financial and legal affairs,

b) if there is a specific, urgent or immediate need, and

c) if no other suitable person (family or friend) has the authority or is willing and able to act on the individual's behalf.

SECTION ONE: PERSONAL INFORMATION

Name: Surname First Name Middle Name	
Maiden Name (if applicable):	
Present Location and Address: Apartment / Street Number Street City Postal Code	
Primary Residence (if different from above): Apartment / Street Number Street City Postal Code	
Date of Hospital or Facility Admission:	Telephone:
Date of Birth:	Fax:
Marital Status: Single / Married / Separated / Divorced / Common-law	Gender: ☐ Male ☐ Female
Social Insurance Number:	Old Age Security Number:
Citizenship	Veterans Service Number:
Personal Health Number:	Language/Communication Method if other than English:
Religion (if applicable):	Place of Birth:

SECTION TWO: REASONS FOR REFERRAL

Is this an urgent Referral?

☐ Yes
☐ No

Why? _____

_____

How are the adult's financial and legal affairs presently being managed?

☐ Self	☐ Government Pension Trusteeship	☐ Family
☐ Power of Attorney	☐ Committeeship	☐ Other
	☐ Representation Agreement	☐ Uncertain

Why is the appointment of the Public Guardian and Trustee necessary to manage the adult's legal or financial affairs? Describe the problem(s) that the adult needs assistance in resolving.

_____

_____

_____

_____

_____

_____

Why do you think this person is unable to make decisions or resolve the problem(s) described previously?

_____

_____

_____

_____

_____

_____

Physicians Name:	
Address:	
Telephone:	Fax:
Continuing Care Case Manager / Care Coordinator Name Telephone	
Is the adult aware of this referral: ☐ Yes ☐ No Unsure	
If yes, what is the adult's response?	

SECTION THREE: FINANCIAL INFORMATION:

Income:

☐ OAS ☐ GAIN

☐ GIS ☐ DVA

☐ CPP ☐ Private Pension/Type: _____

Bank Location:
Personal Property:
Real Property and Vehicles:
Is the property insured? ☐ Yes ☐ No
Name of the Insurance Company:

SECTION FOUR: FAMILY OR OTHER CONTACT PERSONS:

Name Address Province Postal Code Telephone Relationship	Name Address Province Postal Code Telephone Relationship
Name Address Province Postal Code Telephone Relationship	Name Address Province Postal Code Telephone Relationship

Have involved family members/friends been notified about this referral?
Yes / No (please circle one)

If not, why:_____

SECTION FIVE: REFFERAL SOURCE

Referred by:
Date of referral:
Relationship to the Adult being referred
Telephone Number
Address: Apartment / Street Number Street City Postal Code

Please attach any other relevant comments and information and mail this form to:

Greater Vancouver Region
700-808 West Hastings St.
Vancouver, BC V6C 3L3
Tel: (604) 775-1007
Fax : (604) 660-9498
Vancouver, North Shore, Richmond, Delta, Sunshine Coast

Lower Mainland Region
700-808 West Hastings St.
Vancouver, BC V6C 3L3
Tel: (604) 775-1001
Fax: (604) 660-9479
Burnaby, Tri-Cities, North Fraser and Fraser Valley

Vancouver Island Region
1019 Wharf St., 4th floor
Victoria, BC V8W 9J2
Tel: (250) 356-8160
Fax: (250) 356-7442
Vancouver Island, Powell River and Gulf Islands

Interior-North Region
1345 St. Paul St.
Kelowna, BC V1Y 2E2
Tel: (250) 712-7576
Fax: (250) 712-7578
Interior and Northern BC, east and north of Hope

Enquiry BC Toll Free Number: 1-800-663-7867

PUBLIC GUARDIAN AND TRUSTEE OF BRITISH COLUMBIA

PHYSICIAN OPINION OF INCAPABILITY UNDER THE *PATIENTS PROPERTY ACT*

The information on this form is collected under the authority of the *Public Guardian and Trustee Act*. Information collected may be used for the purpose of authorizing the Public Guardian and Trustee to act as Committee of Estate through Certificate or Court Order under the *Patients Property Act*. If you have any questions about the collection and use of this information, please contact Assessment and Investigation Services (AIS).

Directions to the Physician:

This assessment is to be performed by a general practitioner or psychiatrist. It is designed to obtain information on whether there is a mental disability that affects the adult's ability to make decisions. If you need more space for answers, attach additional sheets and/or a copy of your assessment report. Upon completion you may send a copy to the adult, as well as AIS at the PGT.

1. Adult's Personal Information

Name of the adult being assessed: Last Name First Name Initial	
Date of Birth: Month Day Year	For approximately how long have you been treating the adult?
When did you last examine the adult? Date:	Where did the last examination take place? Place:
Do you anticipate seeing the adult again? ☐ Yes ☐ No	If Yes, when will you next see the adult?

3. Mental Status

Mental status evaluation to be based on a direct examination of the adult:

Was the Folstein's Mini Mental Status Examination given?

☐ Yes Adult's Score _____/30

☐ No

If a MMS was not conducted, what other tests or questions were asked of the adult regarding ability to manage financial and legal affairs (and/or person if applicable) and what responses did the adult give. Attach additional sheets if needed.

Was the adult able to follow simple directions / instructions:

☐ Yes

☐ No

Was the adult oriented to time and place?

☐ Yes

☐ No

How would you describe the adult's short term memory?

4. Mental Health Status (adapted from the LTC1)

Attitude	Self-Direction	Affect	Thought Content
☐ Cooperative	☐ Independent	☐ Appropriate	☐ Normal
☐ Indifferent	☐ Needs motivation	☐ Anxious	☐ Delusions
☐ Resistive	☐ Needs direction	☐ Euphoric	☐ Persecutory
☐ Demanding	☐ Dependent	☐ Labile	☐ Guilt
☐ Suspicious		☐ Angry	☐ Obsessions
☐ Hostile		☐ History of mood swings	☐ Phobias
		☐ Blunted	☐ Preoccupation
		☐ Depressed	☐ Other
		☐ Inappropriate	☐ Not able to assess
		☐ Other	

Perceptions	Cognition	Insight	Judgement	Other
☐ Normal	☐ Normal	☐ Good	☐ Good	☐
☐ Hallucinations	☐ Impairment	☐ Partial	☐ Adequate	☐
☐ Auditory	☐ Mild	☐ None	☐ Poor	☐
☐ Visual	☐ Moderate			
☐ Other	☐ Severe			

5. Communication Skills

Comment on responsiveness, vocabulary loss etc.:

6. Medical and Psychiatric Diagnoses

Medical Diagnoses:

Psychiatric History:

Psychiatric Diagnoses:
Prognosis:

7. Functional Status

Is the adult able to perform simple financial transactions?	❑ Yes	❑ No
Is the adult aware of the nature and extent of his/her finances?	❑ Yes	❑ No
Is the adult able to do his or her own banking?	❑ Yes	❑ No
Is the adult able to do his or her own shopping?	❑ Yes	❑ No
Is the adult able to carry out other activities of daily living? If no, please provide examples of activities the adult cannot carry out.	❑ Yes	❑ No

8. Statement of Opinion of Capability to Manage Legal or Financial Affairs

In your opinion (check one)**:**

❑ The adult is **capable** of managing his or her own financial or legal affairs, **or**

❑ The adult has a mental disorder / disability that renders him / her **incapable** of making decisions regarding financial or legal affairs, **or**

❑ I am unable to provide an opinion based on available information and recommend further assessment.

Prognosis: Is the adult's ability to manage his or her affairs likely to improve?
Other Comments:

9. Notification

(Note: a copy of this form may be shared with the adult)

Has the adult been notified of this assessment?

☐ Yes

☐ No

If no, why not?

If the adult has been assessed as incapable of managing financial and legal affairs, please complete the following:

In your opinion would it be injurious to the health of the adult to serve him or her with copies of all the documents relating to the application to appoint a Committee?

☐ Yes

☐ No

If yes, please provide an explanation.

Name of Physician (please print)

Dr._____
Last Name First Name Initial

Signature: _____

Date: _____

Telephone Number: _____ Fax Number: _____

Return this form to:

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Vancouver, BC V6C 3L3
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Fax : (604) 660-9498

Vancouver, North Shore, Richmond, Delta, Sunshine Coast

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700-808 West Hastings St.
Vancouver, BC V6C 3L3
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Fax: (604) 660-9479

Burnaby, Tri-Cities, North Fraser and Fraser Valley

Vancouver Island Region
1019 Wharf St., 4th floor
Victoria, BC V8W 9J2
Tel: (250) 356-8160
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Vancouver Island, Powell River and Gulf Islands

Interior-North Region
1345 St. Paul St.
Kelowna, BC V1Y 2E2
Tel: (250) 712-7576
Fax: (250) 712-7578

Interior and Northern BC, east and north of Hope

Enquiry BC Toll Free Number: 1-800-663-7867

FUNCTIONAL AND DECISION-MAKING ASSESSMENT FORM UNDER THE *PATIENTS PROPERTY ACT* 10.6

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Directions to the Assessor

This assessment may be performed by a clinician or professional health care worker who is an experienced assessor and who has a reasonable rapport with the client. The goal of assessment is to obtain information on the capacities of the person to manage their financial and legal affairs. Please review all referral and available collateral information. If you need more space for answers, attach additional sheets.

SECTION ONE: Assessment Information

Name of the Adult: Last Name First Name Middle Initial	Adult's Date of Birth: Year / Month / Day
Location of the Assessment:	Date of the Assessment: Year / Month / Day

Assessor / Assessment Team Information:

Name	Agency	Position	Contact Information
			Phone: Fax: Email:
			Phone: Fax: Email:

Please list the standards, tools or tests you used as part of this assessment and attach a copy of your assessment report.

Assessment Report Attached?

☐ Yes

☐ No

SECTION TWO: Communication

Does the adult speak and understand English? ☐ Yes ☐ No	If no, with what language or form of communication is the adult most comfortable?
Does the adult require communication supports? ☐ Yes ☐ No	If yes, what communication supports are required?
If someone who assists with communication is available, please include the name and phone number.	

SECTION THREE: Understanding of the Problem

Briefly describe the problem:
How long has the problem existed?
Briefly describe the adult's understanding of the problem. Does the adult understand why he or she is being assessed?
If the adult does not understand, what appears to be preventing understanding?
If the adult expresses understanding, does the adult have suggestions for handling this problem? Are these ideas reasonable considering the problem?

SECTION FOUR: Collateral Information Sources Relevant to the Assessment of Incapability

Please add any new or additional contact information to the Referral Form or attach on a separate piece of paper.

Who are the people available to the adult?

☐ Spouse	☐ Other Relatives	☐ Banker
☐ Children	☐ Friends	☐ Lawyer
☐ Parent	☐ Others	☐ Health Care Worker

Of the people available to the adult, who was contacted for collateral information and why?
Of the people available to the adult, who was not contacted for collateral information and why?
What information was gained through the collection of collateral information in regard to the assessment and potential need for a Certificate? Be specific.
Is more collateral information needed? If so, what collateral information is required?

SECTION FIVE: Understanding of Financial and Legal Affairs

Use the following questions as a guide to determine the financial situation of the adult and the adult's functional ability to manage his/her financial and legal affairs. In your assessment report, please record the adult's response, information collected from collateral sources and your opinion. Use the chart below to summarize your concerns.

Items to be explored with the adult and collateral information sources	Assessor's concerns
1. Do you know your income and its sources?	
2. Do you know what regular bills you need to pay?	
3. Do you have any debt?	
4. Do you have any assets?	
5. Do you have investments or property?	
6. Have you ever needed the help of a lawyer? When and for what?	
7. Do you have a Power of Attorney or is anyone else helping you manage your money?	
8. Do you have a will?	
9. Do you have a bank account? Is there anyone else on this account?	
10. Do you have a credit card?	
11. Do you have a pension from work?	
12. How do you get to the bank?	
13. Do you write cheques? Use a bank debit card?	
14. Do you ever run out of money for food or worry about your rent?	
15. Does your family/friend come to you for money?	
16. Do you keep money in your purse/wallet?	
17. Do you give money to charity?	

SECTION SIX: Summary

How was the adult notified of this assessment? ☐ Mail ☐ Phone ☐ In Person ☐ No Notification	If no notification, please explain.

Has the adult's ability to make decisions or problem solve become significantly worse when compared with his or her abilities in the past?

Has the possibility for pension trusteeship, a Power of Attorney, a Representation Agreement or a Committeeship (as appropriate to the adult's capability) been discussed with the adult? Please give a summary of these discussions or reasons why this has not happened.

Does the adult understand that the Public Guardian and Trustee may be appointed to manage his or her financial or legal affairs?

☐ Yes

☐ No

Is there a discrepancy between the adult's answers and collateral information or your observations?

☐ Yes

☐ No

If so, please describe:

Has the adult expressed any wishes regarding who he or she would like to act as Committee?

☐ Yes

☐ No

Name of the person:

Relationship to the adult:

Reason why the adult would like this person to act as Committee:

Describe the plan in place to notify the adult of the outcome of the assessment.

SECTION SEVEN: Opinion - Assessment of Incapability

In your opinion (check one)**:**

☐ The adult is **capable** of managing his or her own financial or legal affairs, **or**

☐ The adult has a mental disorder / disability that renders him / her **incapable** of making decisions regarding financial or legal affairs.

My opinion is based on the following (please check as appropriate):

☐ Referral information

☐ Functional and decision-making capacity assessment

☐ Medical and psychiatric assessments

☐ Collateral information

This opinion has been provided by:

Name / Signature	Agency	Position
Print Name Signature		
Print Name Signature		

Date: _____