BRITISH COLUMBIA | Ministry of Health

HEALTH AUTHORITY DESIGNATE INFORMATION PACKAGE COVER SHEET FOR CERTIFICATE OF INCAPABILITY

AGA PART 2.1

The purpose of this cover sheet is to provide the health authority designate with contact information and with a list of all the necessary documents for review in considering whether to issue a Certificate of Incapability or for review for Acceptance of Determination of Capability.

1. ABOUT THE ADULT

Last Name	First Name	Middle Name
Maiden Name (if applicable)	Alias (if applicable)	
Gender	Date of Birth (YYYY / MM / DD)	Personal Health Number (PHN)

Current Location

☐ Home ☐ Hospital ☐ Facility ☐ Other (specify):

Address of Current Location

Name of Hospital or Facility (if applicable)

2. PURPOSE OF REVIEW AND REQUIRED DOCUMENTS

HAD to review for:

☐ Whether to issue a Certificate of Incapability

☐ Acceptance of Determination of Capability on:

☐ Second Assessment (S 33 of *Adult Guardianship Act*) or ☐ Reassessment (S 34 of *Adult Guardianship Act*)

Documents Required	Attached by PGT (name)	Attached by Health Authority (name)
PGT Summary of Investigation		
Medical Component of Assessment		
Functional Component of Assessment		
Form 1 with Details of Assessment attached		
Health Authority Designate Checklist		
Previous Asssessment(s) Medical/Functional Forms with Form 1 and Details Attached		

3. URGENCY: IMPORTANT DATES

Specify Commitment	Date (YYYY / MM / DD)	Comments
PGT Protective Measures in place until		
Date Form 2 Certificate of Incapability must be completed		
Other - Specify:		

4. KEY CONTACTS FOR NOTIFICATION

Spouse and/or Near Relative(s) Previously Notified (adult children, parents, adult siblings, grandparents or any other adult related by birth or adoption)

Name	Relationship	Mailing Address	Telephone

5. KEY CONTACTS FOR NOTIFICATIONS: SPECIAL INSTRUCTIONS

Have any previous notifications to the adult been waived due to serious physical or mental harm or significant damage or loss to the adult's property? Please explain.

Please list any spouse or near relatives who were purposefully ***not*** notified throughout the process, and the reason(s).

If known, what is the best way for HAD to notify the adult?

6. ADULT'S INVOLVED CLINICAL AND AGENCY SUPPORTS

Name and Role	Agency	Mailing Address	Telephone
Family Physican			
Medical Component of Assessment – Physician			
Functional Component of Assessment QHCP			
Form 1 – Report of Assessment of Incapability QHCP			
Other			

7. COVER SHEET AND HAD PACKAGE INFORMATION

Cover Sheet and HAD Package Initiated By		Date (YYYY / MM / DD)
Position	Agency	
Address		
Phone	Fax	Email

PRINT CLEAR FORM