

**FORM 15**  
**MENTAL HEALTH ACT**  
[ Section 34.2, R.S.B.C. 1996, c. 288 ]

## NOMINATION OF NEAR RELATIVE

The information on this form is collected pursuant to section 34.2 of the *Mental Health Act*. It will be used to document your nomination of a near relative. Any questions you have about this form may be addressed to the director or staff of this facility.

The *Mental Health Act* requires that the director must send a notice to a near relative immediately after a patient's admission, discharge or an application to the review panel (where applicable).

If you do not name a near relative, the director must choose a near relative to be notified. If the director has no information about your relatives, notification will be sent to the Public Guardian and Trustee.

I, \_\_\_\_\_, would like the near relative named below  
*first and last name of patient (please print)*  
to be notified of my admission or discharge or an application to the review panel (as applicable).

Person to be notified:

<i>first and last name</i>	<i>telephone number</i>
<i>address</i>	<i>postal code</i>

This person's relationship to me is: (please check one only):

- |                                      |                                       |  |  |
|--------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> wife        | <input type="checkbox"/> husband      | <input type="checkbox"/> common-law spouse | <input type="checkbox"/> committee of person |
| <input type="checkbox"/> mother      | <input type="checkbox"/> father       | <input type="checkbox"/> same-sex partner  |  |
| <input type="checkbox"/> grandmother | <input type="checkbox"/> grandfather  | <input type="checkbox"/> friend            |  |
| <input type="checkbox"/> daughter    | <input type="checkbox"/> son          | <input type="checkbox"/> companion         |  |
| <input type="checkbox"/> sister      | <input type="checkbox"/> brother      | <input type="checkbox"/> legal guardian    |  |
| <input type="checkbox"/> half sister | <input type="checkbox"/> half brother | <input type="checkbox"/> caregiver         |  |

<i>signature of patient</i>	<i>date (dd / mm / yyyy)</i>
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*name of designated facility*

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**For office use only**

- No known relative
- Patient declined to complete form

*staff signature*