PROVINCE OF NOVA SCOTIA

IN THE MATTER OF an application to the Public Trustee for consent to medical treatment for

.....
(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "A"

AFFIDAVIT OF PHYSICIAN

(In-house Physician to Home for Special Care)

_____

I, _____ of _____
_____ in the County of_____
and the Province of Nova Scotia, make oath and say that:

1. I am a physician duly qualified and licensed to practise medicine in the Province of Nova Scotia and conduct my practice at and from _____
_____,
(Complete Office Address)
_____.
(Telephone #)

2. Among my patients is one
_____
Family Name Given Names DOB MSI No.

an adult person, herein after called the "patient", now residing at _____
_____, a Home for Special Care located at _____
_____, in the County of _____.

3. I have referred the patient to the _____ Hospital situate at _____, Nova Scotia, for further examination, diagnosis, and treatment.

4. The paper writing now produced before me an marked Exhibit "A" to this my affidavit is a true copy of my report to said hospital relevant to the patient's medical history and present condition.

5. I believe the patient will, when examined by a psychiatrist at the hospital, be found and declared to be not capable of consenting to treatment within the meaning of the *Hospitals Act* [S. 53 and Reg. 10]

SWORN TO at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
)
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

_____

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF an application to the Public Trustee for consent to medical treatment for

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(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "B"

AFFIDAVIT OF ADMINISTRATOR OF HOME FOR SPECIAL CARE

I,_____ of _____
_____, in the County of_____ and the Province of Nova Scotia, make oath and say as follows:

1. I am the Director/Administrator of_____
a Home for Special Care within the meaning of the *Homes for Special Care Act*.

2. Residing at said Home for Special Care is the following individual

Family Name	Given Names	DOB	MSI

an adult person hereinafter called "the patient" who will be referred to a hospital for examination and may require medical and surgical treatment, and who I believe will be found to lack the mental capacity to consent to such treatment.

3. For the reasons set forth in the paper writing now produced before me and marked Exhibit "A" to this my affidavit, I verily believe the patient has no spouse, guardian, or next-of-kin available to consent to medical treatment, and the consent of the Public Trustee may be required.

OR

3. I am not aware of any person claiming or reputed to be spouse, guardian, or next-of-

kin of the patient and willing to consent and have asked the local office of the Department of Community Services to investigate and report upon the availability of a person authorized in law to consent to treatment of this patient.

SWORN TO at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
) _____
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF an application to the Public Trustee for consent to medical treatment for

.....
(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "C"

AFFIDAVIT OF SOCIAL WORKER

I,_____ of _____
_____, in the County of_____ and the Province of Nova Scotia, make oath and say as follows:

1. I am a social worker in the employ of_____ and have on my case load one

_____
Family Name *Given Names* *DOB* *MSI NO.*

an adult person, herein after called "the patient" who will be referred to hospital for examination and may require medical and surgical treatment.

2. The patient resides at_____
(Name & Address of Home for Special Care)
_____, a Home for Special Care within the meaning of the *Homes for Special Care Act*, and may lack mental capacity to consent to such examinations and treatment.

3. I have consulted such of the patient's case files and records as are in custody of my employer and at the said Home for Special Care. I have also made independent investigations and inquiries and have written a report, now attached as Exhibit "A" to this my affidavit, wherein I describe the patient's case history relevant to this matter and my efforts to ascertain

and locate a person authorized by law and willing to consent to such treatment on behalf of the patient.

4. The patient has no spouse, guardian, or next-of-kin available to consent EXCEPT:

Name	*Address & Telephone No.*	*Relationship to patient*
Name	*Address & Telephone No.*	*Relationship to patient*

who was/were solicited by me for such consent and refused for the reasons mentioned in my said report and, in my opinion, such consent is unable to be obtained.

5. The Public Trustee's consent may be required.

SWORN TO at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
)
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

_____

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF an application to the Public Trustee for consent to medical treatment for

.....
(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "D"

AFFIDAVIT OF ATTENDING PHYSICIAN OR SURGEON

I,_____ of _____
_____, in the County of_____ and the Province of Nova Scotia, make oath and say as follows:

1. I am a physician/surgeon duly qualified and licensed to practise medicine in the Province of Nova Scotia, and have personal knowledge of the matters herein deposed to except where stated to be based on information and belief.

2. My credentials and experience include:_____
_____
_____
_____
_____
_____
_____

3. I am Chief or Head of the Department or Service of _____

_____ at _____
Name of Dept. *Name & Address of Hospital*

_____, Nova Scotia.

OR

3. I am a member of the medical staff of_____
Name of Hospital
_____ at _____, Nova Scotia and am
Address of Hospital
designated by Dr._____, the Medical Head or Chief of the Department or Service of_____ at said Hospital, to make this affidavit and report.

4. The above named patient is a patient of this hospital, declared to be without capacity to consent to treatment by a Declaration of Capacity made pursuant to the *Hospitals Act*.

5. I have examined the patient and the patient's medical records, including reports of examinations and clinical and laboratory tests and investigations compiled since his/her referral to this hospital and have conferred with my colleague(s):

Dr._____

Dr._____

who has/have been consulted in the examination and diagnosis of this patient and who will be asked to concur in this report.

6. The paper writing now produced before me and marked Exhibit "A" to this my affidavit is a report of the examination and diagnosis of the patient at this hospital and description of the medical or surgical treatment or procedure recommended

7. In my opinion, all tests and investigations reasonably required, up to this time, have been performed and the patient is in need of the treatment or procedure recommended.

8. Such treatment or procedures will be performed by me or under my supervision or by/or under the supervision of _____ _____, a qualified medical staff designated by the said Medical Chief of the Department or Service of _____ _____ at the previously mentioned hospital.

SWORN TO at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
)
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

_____

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF an application to the Public Trustee for consent to medical treatment for

.....
(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "E"

AFFIDAVIT OF CONSULTING PHYSICIAN/SURGEON
(who was consulted concerning the examination and diagnosis of the patient)

I,_____ of _____ _____, in the County of_____ and the Province of Nova Scotia, make oath and say as follows:

1. I am a physician/surgeon duly qualified and licensed to practise medicine in the Province of Nova Scotia and have as my professional address _____ _____

2. On or about the _____ day of _____, 2004, I participated in the examination and diagnosis and/or was consulted re the examination and diagnosis of the above named patient at_____ located at _____ .
Name of Hospital *Address of Hospital*

3. The paper writing now produced before me and marked Exhibit "A" to this my Affidavit is a report of the examination and diagnosis of the above noted patient at the _____ _____ and a description of the medical or surgical treatment or
Name of Hospital
procedures recommended.

4. I concur in the said diagnosis and recommendations.

SWORN TO at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
) _____
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

PROVINCE OF NOVA SCOTIA

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.....
(herein called the "patient")

- and -

IN THE MATTER OF *The Hospitals Act,* R.S.N.S. 1989, c.208

FORM "F"

APPLICATION

1. THE APPLICANT, who has assembled the documents in this application for presentation to the Public Trustee, is the:

( ) Medical Director)
)
( ) Administrator) of _____
) *(name of hospital where patient is to be treated)*
( ) Social Work Director)

and is more specifically identified as follows:

_____

(Family Name) *(Given Names)* *(Telephone Number)*

Business Address: _____

2. THE PATIENT may be identified by reference to the following data:

_____

(Family Name) *(Given Names)* *(Date of Birth)*

_____

(Sex/Gender) *(MSI No.)* *(Social Insurance No.)*

_____
(Former names or aliases, if any)

3. THE PATIENT normally resides at:

_____, _____
(Name of Home for Special Care in which patient resides) *(Civic Address)*

_____,_____
(*Village, Town, City)* *(Province)* *(Postal Code)*

4. The person who usually supervises the care and management of this patient at the address set-out in paragraph 3 hereof is:

_____ _____ _____
(Family Name) *(Given Names)* *(Title)*

_____
(Telephone No.)

5. The patient is scheduled to be treated at:

_____ on or about the
(Name and Address of Hospital)

_____ day of _____, 2004.

6. The treatment or procedure proposed for this patient at the said hospital and the need therefore are particularly described and explained in the exhibits to the affidavits of the medical doctors, which are filed with this application, namely:

(a) the affidavit of Dr. _____ sworn the _____day of _____, 2004;
(b) the affidavit of Dr. _____ sworn the _____day of _____, 2004;
(c) the affidavit of Dr. _____ sworn the _____day of _____, 2004;

7. As proof that the above named patient is not capable of consenting to the proposed treatment, there is filed with this application a DECLARATION OF CAPACITY TO CONSENT TO TREATMENT (*Hospitals Act,* Sec. 53, Regulation 10, Schedule "H") made by Dr. _____, Psychiatrist, and dated the _____ day of _____, 2004.

8. As proof that all reasonable efforts have been made to find and obtain the consent of a person authorized by law to consent on behalf of the patient to medical or surgical treatment and, as proof that the patient has no guardian, spouse or next-of-kin available to consent or that such consent is unable to be obtained, there is (are) filed with this application;

(a) the affidavit of _____ Administrator/Director of _____
_____ *(Name of Deponent)*

_____ sworn the _____ day of _____, 2004;
(Name of Home for Special Care)

AND/OR

(b) the affidavit of _____ , a Social Worker employed by

_____, sworn the _____ day of _____, 2004.
(Name of Employer)

9. **REQUEST FOR CONSENT**

The Public Trustee is requested to consent, on behalf of the patient, to the medical or surgical treatment or procedure that is described and explained in the affidavits of the medical doctors set-out in paragraph 6 of the foregoing application.

10. **DECLARATION OF APPLICANT**

I, the undersigned applicant, do solemnly DECLARE THAT the statements of fact set forth in this application are true to the best of my knowledge, information and belief.

I make this declaration conscientiously, believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the *Canada Evidence Act*.

DECLARED at_____)
in the County of_____)
and Province of Nova Scotia this)
_____day of_____, 2004)
)
BEFORE ME)
)
)
_____)
A Commissioner of Oaths, Justice of)
the Peace, Notary Public or Barrister and/or)
solicitor authorized or appointed to)
administer oaths in the Province of Nova)
Scotia.)

_____

PROVINCE OF NOVA SCOTIA

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SCHEDULE"H"

DECLARATION OF CAPACITY TO CONSENT TO TREATMENT

(Section 53 *Hospitals Act* and Regulation 10)

I, Dr._____, a psychiatrist within the meaning of the *Hospitals Act* and being on the staff of _____ Hospital, having personally examined _____ in the said hospital, on the _____ day of _____ 2004, hereby declare that in my opinion the said patient:

CHECK ONE: _____ is capable of consenting to the following treatment(s), or

_____ is not capable of consenting to the following treatment(s)

_____

_____

_____

_____

_____

_____

In arriving at this opinion I have considered whether or not the said person

(a) understands the condition for which the treatment is proposed;

(b) understands the nature and purpose of the above treatment or treatments;
©) understands the risks involved in undergoing the treatment;
(d) understands the risks involved in not undergoing the treatment;
(e) whether or not his/her ability to consent is affected by his/her condition.

Observations made by me personally supporting this opinion:

_____
_____
_____
_____
_____
_____

Information supporting it given to me by others:

_____
_____
_____
_____
_____
_____

Identify the source of the information: _____

Date of Admission to Facility: _____

Patient: (Check One): Formal _____ Informal _____

_____ _____

(Date) *(Signature of Psychiatrist)*