

KMK LAW CORPORATION
BARRISTERS & SOLICITORS
PARK PLACE, SUITE 600 – 666 BURRARD STREET
VANCOUVER, B.C., CANADA V6C 2X8
Phone: (604) 694-0999 Toll-free: 1(877) 394-0999
Facsimile: (604) 683-3471
Email: info@kmklaw.net
www.kmklaw.net & www.kmklaw.ca

Representation Agreement Questionnaire

We ask that you complete this questionnaire as thoroughly as possible before we meet because it will provide us with essential information and help us to identify the items we should discuss with you. Please call us if you have any questions about completing this questionnaire.

The questionnaire is divided into three parts. The first part asks for information about you and your family. The second part is intended to assist you to decide what should be in your Representation Agreement. Although you may not be able to answer all the questions in that part, you will at least have an opportunity to think about them, and, perhaps, discuss them with your doctor before we meet.

The questionnaire may not elicit from you all the information you wish to give us or that we will wish to obtain from you. Please make note of all additional information concerning you, your family, and your wishes that you feel may be necessary or helpful to us in advising you.

Please note that the questionnaire assumes that only British Columbia law applies to you. If this situation is not the case, it may be necessary for you to consult a lawyer in another jurisdiction. We would be pleased to assist you with seeking counsel in another jurisdiction.

Please complete only one questionnaire per couple.

Date: _____

PART 1—CLIENT INFORMATION

1. INFORMATION ABOUT YOU

Name (full)

Other names you are or have been known by
(for example, your name is Shaun but you use “Sandy”)

Address

Occupation
(if retired, also include former occupation)

Date of birth [dd/mm/yy] Place of birth [city/province/country]

Relationship status (including plans to marry)

single engaged married separated
 divorced widowed cohabiting

Telephone no. [home]

Telephone no. [work]

Fax no. [home]

Fax no. [work]

Mail/fax to be sent to:

home work

Telephone before faxing?

yes no

2. INFORMATION ABOUT YOUR SPOUSE/PARTNER

Full name of spouse/partner

Other names your spouse/partner is or has been known by

Occupation
(if retired, also include former occupation)

Date of birth

Relationship status (including plans to marry)

single engaged married separated
 divorced widowed cohabiting

Your marriage is

a legal marriage
 a common law marriage

Telephone no. [home]

Telephone no. [work]

Fax no. [home]

Fax no. [work]

Mail/fax to be sent to:

home work

Telephone before faxing?

yes no

3. OTHER PERSONAL RELATIONS

Are you now cohabiting with someone other than a person to whom you are legally married: yes no

Name: *[name]*

4. YOUR CHILDREN

The word “child” includes a child of your marriage, a child born outside of marriage, and an adopted child. Please provide the following information for each of your children and your spouse or partner’s children.

Full name	Age	Is the child yours? Your spouse/partner’s? Or both?	Address

5. YOUR HEALTH CARE PROVIDERS

Name and phone number of your doctor(s):

May we have your permission to contact your doctor(s)? yes no

Please provide us with the names and phone numbers of any other person whom we should contact for information about you:

6. IF THE CLIENT IS INCAPABLE OF PROVIDING DETAILED INFORMATION, WHO IS PROVIDING IT?

Name (full)

Address

Occupation

(if retired, also include former occupation)

Relationship to the client:

Telephone no. *[home]*

Telephone no. *[work]*

Fax no. *[home]*

Fax no. *[work]*

Mail/fax to be sent to:

home work

Telephone before faxing?

yes no

7. USING THE REPRESENTATION AGREEMENT

When do you anticipate using the Representation Agreement, and why?

PART 2—CLIENT INFORMATION

1. HEALTH CARE REPRESENTATIVES

- (a) Who do you want to name as your Original Representative to make decisions about health care and personal care?

	Person 1	Person 2
Full name		
Address		
Occupation		
Relationship to you		
Home phone		
Home e-mail		

Home fax		
Work phone		
Work e-mail		
Work fax		
	<input type="checkbox"/> Joint with other named	<input type="checkbox"/> Joint with other named

(b) Who do you want to name as your Alternate Representative to make decisions about health care and personal care, if your Original Representative is unable to act?

	Person 1	Person 2
Full name		
Address		
Occupation		
Relationship to you		
Home phone		
Home e-mail		
Home fax		
Work phone		
Work e-mail		
Work fax		
	<input type="checkbox"/> Joint with other named	<input type="checkbox"/> Joint with other named

2. YOUR MONITOR

No monitor wanted

or

Name (full)

Address

Occupation
(if retired, also include former occupation)

Relationship to you:

3. HEALTH OR PERSONAL CARE DECISIONS

(a) Do you want your representative to make decisions concerning:

(i) major health care yes no

(ii) minor health care yes no

Major health care includes:

- major surgery
- any treatment involving a general anaesthetic
- major diagnostic or investigative procedures
- radiation therapy
- intravenous chemotherapy
- electroconvulsive therapy
- kidney dialysis
- laser surgery
- any other health care designated by Regulation to or defined by the *Health Care (Consent) and Care Facility (Admission) Act*, as major health care

Minor health care means any health care that is not major health care.

(iii) where and with whom you reside? yes no

(iv) whether to physically restrain, move, or manage you, or to have you physically restrained, moved, or managed, despite your objections? yes no

(v) giving consent to minor health care or major health care even though you may refuse to give consent at the time the health care is

provided? yes no

(vi) accepting a facility care proposal under the *Health Care (Consent) and Care Facility (Admission) Act* for you to be admitted to any kind of care facility? yes no

(vii) making arrangements for the temporary care, education, and support of: yes no

A. your minor children yes no

B. any other persons you care for or support yes no

(viii) making decisions to refuse life-supporting care or treatment for you? yes no

(b) Do you want your representative to be able to give or refuse consent on your behalf for:

	Consent to	Refuse to	Both
(i) abortion (unless recommended in writing by the treating physician and at least one other medical practitioner who has examined you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) electroconvulsive therapy (unless recommended in writing by the treating physician and at least one other medical practitioner who has examined you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) psychosurgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) removal of tissue from your body for implantation in another human body or for medical education or research	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | | |
|-------|---|--------------------------|--------------------------|--------------------------|
| (v) | experimental health care involving a foreseeable risk to you that is not outweighed by the expected therapeutic benefit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (vi) | participation in a health care or medical research program that has not been approved by a committee referred to in section 2 of the Health Care Consent Regulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (vii) | any treatment, procedure, or therapy that involves using aversive stimuli to induce a change in behaviour | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(c) When do you want this Agreement to come into effect?

- immediately
- only when you are no longer capable of giving informed consent

(d) Do you want your representative to be able to charge a fee for acting as your representative? yes no

If yes, this decision is to be discussed with your lawyer.

(e) Do you wish to be allowed to die with dignity— i.e., not kept alive by artificial means or heroic measures? yes no

(f) Do you wish medication administered for pain, even if those drugs might cause you to die sooner? yes no

(g) Do you have any other specific directions concerning your health or personal care (e.g., no blood transfusions, die at home)?

4. TERM OF THE AGREEMENT

When will the Representation Agreement be effective?

- on the date it is executed
- on the date you decide to trigger it into effect
- on mental infirmity as confirmed in writing by two licensed doctors

When will the Representation Agreement be terminated?

- on death, revocation, or Court Order
- on date or event specified: _____

5. LOCATION OF THE AGREEMENT

Where will the original Representation Agreement be kept?

6. LIVING WILL

Have you already signed a Personal Declaration (Living Will), Alternate Medical Directive, or Medical Care Proxy setting out your wishes as to the medical care you wish to receive if you should become incapacitated?

- yes: Please provide us with a copy.
- no: Would you like to prepare such a document? yes no

7. NOMINATION OF COMMITTEE

Have you signed a Nomination of Committee in which you name the person or corporate trustee you would like the Court to appoint as your legal guardian if you should become incapable of managing your financial affairs or your person?

- yes: Whom did you appoint?
- no: Would you like to? yes no

Full name	Address	Relationship to you

Please indicate whether the persons you name are to act as primary, alternate, or co-Committees.

Please provide us with the following information for the person(s) you wish to act as Committee(s) of your person:

same person(s) as I want to be Committee(s) of my financial affairs

Name	Address	Relationship to you

Please indicate whether the persons you name are to act as primary, alternate, or co-Committees.
