NOVA SCOTIA

Public Trustee Office
Health Care Decisions Division

Request for Decision for Health Care, Home Care, or Placement Pursuant to the *Personal Directives Act (PDA)*

Client Information

Client Name _____Health Card # _____

Date of Birth _____ Facility _____

Address _____ Postal Code _____

Client Capacity: PDA - Form 1

Has a physician completed a FORM 1? ☐ YES ☐ NO Included with this request? ☐ YES ☐ NO

Previously submitted ☐ YES ☐ NO Form 1 Date _____

Does this person have any known relatives or someone legally authorized to make Health Care, Home Care or Placement decisions on their behalf? ☐ YES ☐ NO

Does this person have a Personal Directive or EPOA? ☐ YES (If yes, submit) ☐ NO

Why is the guardian, delegate or relative not making this decision?

_____

_____

SDM ID Form Must be Submitted with all Initial Requests.

Presenting Medical Situation

_____

_____

_____

WHAT ARE YOU REQUESTING / RECOMMENDING? Be specific and provide as much detail as possible.

Complete a Medication Sheet (Print Clearly) for Multiple Medications or Provide MAR.

_____

_____

_____

_____

Pertinent Wishes, Values or Beliefs

Provide information about the person's ethnic, cultural, or religious background or expressed wishes that may apply to this decision

_____

_____

_____

_____

Is there a less restrictive or intrusive option? _____

_____

Additional comments/recommendations pertaining to this request _____

_____

Attach Supporting/Requested Documents which may include: Admission Assessments, Medication List, Care Plan, Consultation Notes, Progress Notes, Physician / OT / PT / Dietitian Assessments/Recommendations.

Requestor Details and Signature

Print Name _____ Signature _____

Position _____ Facility/Organization _____

Address _____ Postal Code _____

Phone # _____ **RETURN FAX #** _____

Is this request for Outpatient Electroconvulsive Therapy (ECT) ☐ YES ☐ NO

Has this client had ECT before? ☐ YES ☐ NO

Recommended ECT Treatment Schedule _____

_____

ECT Treatments will be administered by Doctor _____, License #_____

a Licensed Psychiatrist at _____ Hospital.

Psychiatrist Signature _____ Date_____

Send **Completed and Signed** Request Forms, with supporting documentation to:

HEALTH CARE DECISIONS DIVISION

Confidential Fax #: 902-428-2159

Confidential Telephone #: 902-424-4454

Email: publictrusteeHCD@novascotia.ca

Website: Nova Scotia Public Trustee Office Forms and Guides | novascotia.ca