Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 12 – *Northwest Territories Mental Health Act*

DESIGNATION OF SUBSTITUTE DECISION MAKER

The purpose of this form is to designate a substitute decision maker to make treatment decisions on behalf of a patient who is subject to a *Treatment Decision Certificate*.

This designation of the substitute decision maker will cease to have effect upon expiration or cancellation of the *Treatment Decision Certificate*. Expiration of the *Treatment Decision Certificate* occurs when the person ceases to be a patient.

PATIENT INFORMATION

Name of Patient	Gender	Date of Birth (DD-MM-YYYY)

Address of Patient

Street	Community	Postal Code

Designated Facility (where admitted)

Name		
Street	Community	Postal Code

Patient Status under the *Mental Health Act*

☐ Voluntary Patient ☐ Involuntary Patient ☐ Other Specify: _____

Treatment Decision Certificate

Date of Issue (DD-MM-YYYY)	Time of Issue	Attending Medical Practitioner who issued certificate

SUBSTITUTE DECISION MAKER INFORMATION

Name of Substitute Decision Maker		Telephone Number
Address	Community	Postal Code
Relationship to Patient (see selection criteria on next page)		

I _____ have reasonable grounds to believe that the designated substitute decision maker:
(Attending Medical Practitioner or Director of Designated Facility)

- Is available to make treatment decisions on behalf of the patient;
- Is willing to assume responsibility for making treatment decisions on behalf of the patient;
- Is mentally competent;
- Has been in personal contact with the patient within the previous 12 months; and

The substitute decision maker is designated based on the following criteria:

A. The substitute decision maker is eligible as one of the following persons:
- ☐ Lawful custody of or lawful authority of minor
- ☐ Legal guardian
- ☐ Agent under a Personal Directive within the *Personal Directives Act*

B. None of the persons listed in A. apply, and the substitute decision maker is the adult relative first listed, who is the oldest of two or more relatives of the same category:*
- ☐ Spouse
- ☐ Child
- ☐ Parent
- ☐ Sister/Brother
- ☐ Grandparent
- ☐ Grandchild
- ☐ Aunt/Uncle
- ☐ Niece/Nephew

C. None of the persons listed in A. or B. apply, and the substitute decision maker is an:*
- ☐ Adult friend

D. A person listed in B. or C. applies, and the patient:* **
- ☐ Objects to the nearest relative acting as their substitute decision maker,
- ☐ Expressed a wish as to who should be designated.

I believe the patient is competent to participate in the decision regarding their substitute decision maker, and subsequently selected the following as their substitute decision maker:
- ☐ Spouse
- ☐ Child
- ☐ Parent
- ☐ Sister/Brother
- ☐ Grandparent
- ☐ Grandchild
- ☐ Aunt/Uncle
- ☐ Niece/Nephew
- ☐ Adult friend

Dated this _____ day of _____, 20 _____ at _____ .
(Time)

X PLEASE PRINT FORM TO SIGN

Printed Name of Attending Medical Practitioner or Director of Designated Facility | Signature

Address	Community	Postal Code

TO BE COMPLETED BY SUBSTITUTE DECISION MAKER

I accept the duties and responsibilities of substitute decision maker. I will make treatment decisions in the best interests of the patient, taking into consideration decisions they expressed or would otherwise have made when mentally competent.

Printed Name _____ X _____ Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

* ONLY TO BE COMPLETED BY SUBSTITUTE DECISION MAKER THAT IS A PERSON LISTED IN B, C, OR D

I certify that:

- ☐ My relationship to the patient is: _____ .
- ☐ I have been in personal contact with the patient *within the previous 12 months*.
- ☐ I am willing to assume responsibility for making treatment decisions on behalf of the patient.

Printed Name _____ X _____ Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

** ONLY TO BE COMPLETED BY PATIENT IF D APPLIES

I agree with the designation of the identified substitute decision maker.

Printed Name _____ X _____ Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

Distribution Note:

- This form must be filed with the director of the designated facility where the patient is admitted involuntarily.
- Copies of this form need to be provided to the patient and substitute decision maker, and if applicable:
  (a) Person designated by patient to receive information
  (b) A person with lawful custody or authority if the patient is a minor
  (c) Legal guardian
  (d) Agent under a personal directive

The personal health information on this form is being collected under the authority of the *Mental Health Act*. It is protected by the privacy provisions under the *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about this form, please contact the Clinical Mental Health Program Specialist at 867-767-9061 or mhact_reviewboard@gov.nt.ca