ENTRUST LLP
LAWYERS

REPRESENTATION AGREEMENT QUESTIONNAIRE

****NOTE: Please do your best to complete all required fields below. If you require additional space for any portion of the form, please use the space provided at the end. If you are uncertain of the answers to any of the fields below, please leave blank and email the form as is to kokimaw@entrustlaw.ca. A member of the Entrust team will be in touch to discuss the matter with you further. Thank you****

REPRESENTATION AGREEMENT INSTRUCTIONS				
Do you have an existing Representation Agreement in which you name someone to make, or assist you in making, health and personal care decisions? (If yes, please provide a copy)			☐ Yes ☐ No	
REPRESENTATIVES				
Representative - Names	Address/Phone	Relationship	Appointment	
			☐	Primary
			☐	Alternate
			☐	Joint with others named
			☐	Primary
			☐	Alternate
			☐	Joint with others named
			☐	Primary
			☐	Alternate
			☐	Joint with others named
			☐	Primary

			☐	Alternate
			☐	Joint with others named

If you named your spouse/partner as your personal representative, do you wish for them to continue to act as your representative should your relationship end?	☐	Yes	☐	No
Do you have minor children or dependents?	☐	Yes	☐	No
Do you have pets?	☐	Yes	☐	No

HEALTH OR PERSONAL CARE DECISIONS

Major health care includes:

- major surgery
- any treatment involving a general anesthetic
- 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.

Personal Care includes:

- deciding where and with whom you reside
- deciding whether to physically restrain, move, or manage you, or to have you physically restrained, moved, or managed, despite your objections
- giving consent to minor health care or major health care even though you may have refused to give consent previous times the health care was to be provided
- 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
- making arrangements for the temporary care, education, and support of your minor children or any other person you care for or support

Do you want your representative to make decisions concerning:

	Yes	**No**
major health care	☐	☐

minor health care	☐	☐
personal care	☐	☐
making decisions to refuse or continue life-supporting care or treatment for you?	☐	☐

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

	Yes	No	N/A
abortion (unless recommended in writing by the treating physician and at least one other medical practitioner who has examined you)	☐	☐	☐
electroconvulsive therapy (unless recommended in writing by the treating physician and at least one other medical practitioner who has examined you)	☐	☐	☐
psychosurgery	☐	☐	☐
removal of tissue from your body for implantation in another human body or for medical education or research	☐	☐	☐
experimental health care involving a foreseeable risk to you that is not outweighed by the expected therapeutic benefit	☐	☐	☐
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	☐	☐	☐
any treatment, procedure, or therapy that involves using aversive stimuli to induce a change in behavior	☐	☐	☐

Please provide your specific instructions for the following:

	Does Want	Does Not Want
cardiac resuscitation	☐	☐
mechanical respiration	☐	☐
tube feeding and other artificial forms of nutrition (food) and hydration (water)	☐	☐
blood or blood products	☐	☐
surgery	☐	☐
invasive diagnostic tests	☐	☐
kidney dialysis	☐	☐

Antibiotics	☐	☐
When the time comes, do you wish to be allowed to "die with dignity" – i.e. not kept alive by artificial means or heroic measures/only to provide comfort measures?		☐ Yes ☐ No
In the situation in (c), do you wish medication administered for pain, even if those drugs might cause you to die sooner?		☐ Yes ☐ No
Do you have any other specific directions concerning your health or personal care (e.g., no blood transfusions, die at home)?		☐ Yes ☐ No
If yes, please specify any special directions (and include more detail, if more room is required use the space provided at the end of this form – Reference Part 5 – Special Directions)		
Organ Donation		☐ Yes ☐ No
Medical Assistance in Dying (MAiD): If you have a grievous and irremediable medical condition that is causing enduring suffering that is intolerable, do you want your Representative to give or refuse consent on your behalf to a physician-assisted termination of your life?		☐ Yes ☐ No
YOUR HEALTH CARE PROVIDERS		
Name and phone numbers of your doctor(s):		
Name	**Phone Number**	
May we have your permission to contact your doctor(s)?		☐ Yes ☐ No

IF YOU HAVE YET TO COMPLETE THE WILL QUESTIONNAIRE, AND DESIRE TO DO SO PLEASE JUST CLICK

HERE