KMK LAW CORPORATION
BARRISTERS & SOLICITORS

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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 third part is for our use.

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.

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

Marital status (including plans to marry)

❑ single ❑ engaged ❑ married ❑ separated
❑ divorced ❑ widowed ❑ common law

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

Full name of spouse

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

Occupation
(if retired, also include former occupation)

Date of birth

Your marriage is
❑ a legal marriage
❑ a common law marriage
❑ a same-sex marriage-like relationship

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? Spouse's? Or from this marriage?	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 who 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		
Areas of authority		
Capacity	❑ Joint with others named	❑ Joint with others 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		
Areas of authority		
Capacity	❑ Joint with others named	❑ Joint with others named

2. YOUR MONITOR

No monitor wanted ❑ (solicitor must complete Form 2)

or

Name (full)

Address

Occupation
(if retired, also include former occupation)

Relationship to you:

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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
- radiation therapy
- intravenous chemotherapy
- electroconvulsive therapy
- any treatment involving a general anaesthetic
- major diagnostic or investigative procedures
- 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	❑	❑	❑
(ii)	electroconvulsive therapy	❑	❑	❑
(iii)	psychosurgery	❑	❑	❑
(iv)	removal of tissue from your body for implantation in another human body or for medical education or research	❑	❑	❑
(v)	experimental health care involving a foreseeable risk to you that is not outweighed by the expected therapeutic	❑	❑	❑

	benefit			
(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	❑	❑	❑
(vii)	any treatment, procedure, or therapy that involves using aversive stimuli to induce a change in behaviour	❑	❑	❑

(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 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 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. ENDURING POWER OF ATTORNEY

Have you signed an Enduring Power of Attorney giving someone authority to look after your financial affairs if you should become incapacitated?

- ❑ Yes (*please provide us with a copy*)
- ❑ No
  Would you like to? ❑ yes ❑ no

If yes, please provide us with the following information for the person(s) you wish to act as your attorney(s):

Full name	Address	Relationship to you

If you wish to have more than one attorney, please tell us whether the attorneys must act together, or whether they may act separately.

When do you wish the Power of Attorney to be effective?

- ❑ Immediately
- ❑ Only when two doctors declare you are incapable of managing your affairs

Do you want your attorney to be able to appoint a replacement attorney? ❑ yes ❑ no

8. 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.

PART 3—FOR LAW FIRM'S USE

Conflicts check complete?

Date(s) of meeting(s) with client:

Persons present at meeting:

s. 9 capacity?

s. 7 capacity?

Date(s) of previous representation agreements:

Significant difference(s)?

Reasons for changes:

Representative's remuneration:

Monitor:

RA required by: Date: _____

❑ mail ❑ courier ❑ fax (phone first?)

Estimates:

Fees: _____ + Taxes ❑ yes ❑ no

+Wills Notice: ❑ yes ❑ no + Photocopies/Mailing/Fax ❑ yes ❑ no

Location of executed original(s):

Referred to doctor for medical advice:

Languages:

English read? ❑ yes ❑ no

English spoken? ❑ yes ❑ no

Translator required? ❑ yes ❑ no