



# REFERRAL FORM

## Assessment and Investigation Services

### Referral Criteria:

It is appropriate to refer an adult (over the age of 19 years) to the Public Guardian and Trustee of British Columbia if there is:

- a) a concern about the adult's mental capability to manage financial and legal affairs,
- b) a specific, urgent or immediate need, and
- c) no other suitable person (family or friend) has the authority or is willing and able to act on the adult's behalf

### PERSONAL INFORMATION

Legal name of adult being referred:		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	First Name	Middle Name
<input type="text"/>	<input type="text"/>	
Maiden Name	Alias (if applicable)	
Date of birth: (MM/DD/YY)	Gender	<input type="text"/>
<input type="text"/>	Name of Spouse (if applicable)	<input type="text"/>
Marital status:	<input type="text"/>	<input type="text"/>

Current location:		
Street	<input type="text"/>	Apartment / suite number <input type="text"/>
City	<input type="text"/>	Postal Code <input type="text"/>
		Phone <input type="text"/>
Name of hospital or facility (if applicable):	Date of hospital or facility admission: (MM/DD/YY)	
<input type="text"/>	<input type="text"/>	

Primary residence (if different from above):		
Street	<input type="text"/>	Apartment / suite number <input type="text"/>
City	<input type="text"/>	Postal Code <input type="text"/>
		Phone <input type="text"/>

Social Insurance #:	<input type="text"/>	Personal Health #:	<input type="text"/>
DVA #:	<input type="text"/>	Old Age Security #:	<input type="text"/>
Citizenship:	<input type="text"/>	Place of Birth:	<input type="text"/>
Aboriginal status:	<input type="text"/>	AANDC Status #:	<input type="text"/>
Religion (if applicable):	<input type="text"/>	Language/communication method if other than English:	<input type="text"/>
Is the adult aware of this referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
If yes, what is the adult's response?			
<input type="text"/>			

**MEDICAL INFORMATION**

Physician's Name:

Address:

Telephone:  Fax:

The Adult is Assisted by:

Health Authority

Program & Location

Contact Name  Phone  Email

**FINANCIAL INFORMATION:**

Income:

OAS     GIS     CPP     DVA     Provincial Income Assistance

Private Pension: Type & Location

Assets:

Bank Name	Branch & Address	Account Number	Approximate Balance

Does the Adult Own any of the Following:

Real Estate?     Yes     No    Address

If Yes, is the Real Estate Insured?     Yes     No     Unsure    Name of Insurance Company

Investments?     Yes     No    Name of Investment Company

Vehicles?     Yes     No    Description

Any Other Personal Property, Excluding Real Estate?     Yes     No    Description & Insurance Information

Do any of the adult's assets require urgent protection?     Yes     No

If yes, please provide details

## REASONS FOR REFERRAL

Describe the problem(s) that the adult needs assistance in resolving and the urgent or immediate need.

What is the concern you have regarding the adult's mental capability to manage financial and legal issues?

How are the adult's financial and legal affairs presently being managed?

- Self                       Government Pension Trusteeship                       Committeeship                       Other  
 Power of Attorney    Representation Agreement                       Family                       Uncertain

Is there another person willing and able to act on the adult's behalf?

### FAMILY OR OTHER CONTACT PERSONS:

1. Name:

Address:

Telephone:

Email:

Relationship:

2. Name:

Address:

Telephone:

Email:

Relationship:

3. Name:

Address:

Telephone:

Email:

Relationship:

4. Name:

Address:

Telephone:

Email:

Relationship:

Have involved family members/friends been notified about this referral?  Yes  No

If not, why:

**REFERRAL SOURCE**

Referred by: <input type="text"/>	Date of referral: <input type="text"/> (MM/DD/YY)		
Relationship to the adult being referred: <input type="text"/>			
Telephone number: <input type="text"/>	Email: <input type="text"/>		
Address:			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Apt/Suite #	Street	City	Postal Code
For CFA Manager's use only: Do you anticipate the PGT to be involved in making a CFA decision?:			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

**Please attach any other relevant comments and information.**

**If you have any questions about completing this form, feel free to contact us at the numbers listed below.**

**Mail, fax or Email the completed form as per the information below**

**Assessment and Investigation Services**

700 - 808 West Hastings St.  
Vancouver, BC V6C 3L3

Toll Free Tel: 1 877.511.4111  
Local: 604.660.4507  
Toll Free Fax: 1 855.660.9479  
Local Fax: 604.660.9479  
E-Mail: AIS-PDS@trustee.bc.ca

**\*Note:** To email this form, the user must have Adobe Pro installed. To email without Adobe Pro: print the completed form, scan it and attach the scan to your email.

The information in this form is collected for the purpose of protecting the legal rights and financial or personal care interests of an adult who may not be able to manage his or her affairs independently. The identity of a person who makes a report of abuse or neglect to the PGT is protected from disclosure by law. All information provided to the PGT is held in the strictest confidence, in accordance with BC's *Freedom of Information and Protection of Privacy Act* and other legislation.

If you have any questions about the collection, use or disclosure of the information in this form, please contact the PGT's Information and Privacy Officer, 700-808 West Hastings Street, Vancouver, BC, V6C 3L3, tel. 604. 660.5104.