Developed by FHA OCT2020
Revised by PHSA FEB 2021

NOMINATION OF NEAR RELATIVE FORM 15 QUICK GUIDE

General instructions:

- Form 15 should be completed immediately after involuntary admission
- If the patient gives no information, the form is complete when the "patient declined to complete the form" box is cheked and the "staff signature" is complete
- If the patient reports no relatives, the form is complete when the "no known relative" box and "staff signature" is complete
- If the patient reports a relative but will not sign, the form is complete when all the other sections are complete

Name of patient:
Standard: Consistent with the name on the most recent Form 4

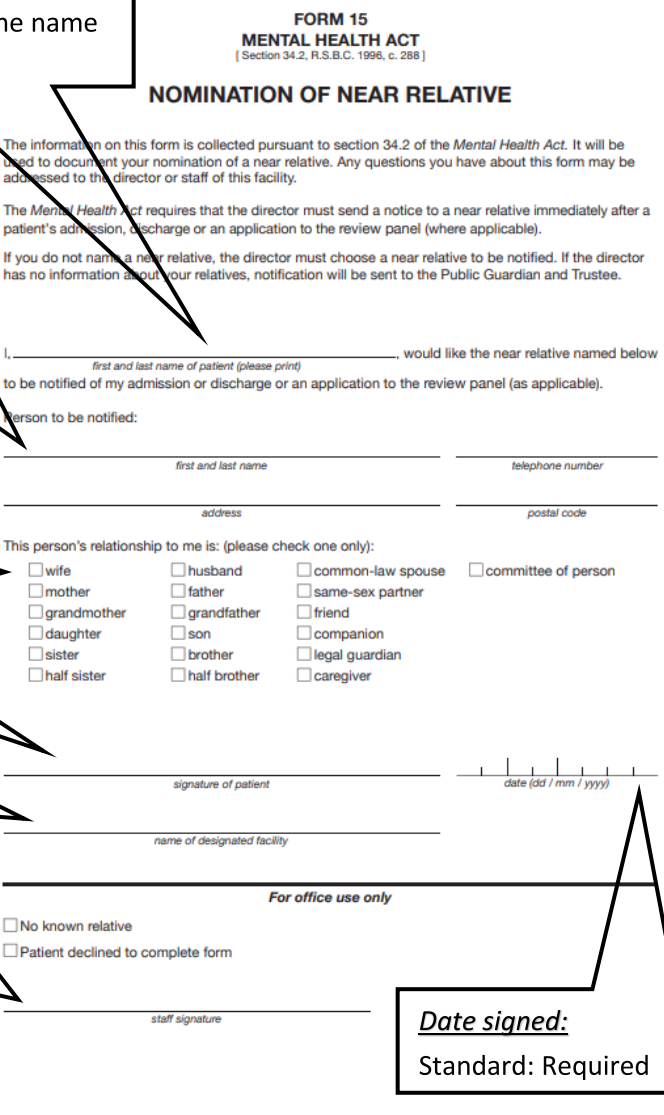
Person to be notified:
Standards:
- First and last name: must match the name on the Form 16
- Telephone number: any format
- Address: any format
- Postal code: any format

This person's relationship:
Standard: A box is checked

Signature of patient:
Standard: Any format

Name of facility:
Standard: BC Children's Hospital

For office use only - section:
Standards:
- No known relative: any format
- Patient declined: any format
- Staff signature: any format



FORM 15
MENTAL HEALTH ACT
[Section 34.2, R.S.B.C. 1996, c. 288]

NOMINATION OF NEAR RELATIVE

The information on this form is collected pursuant to section 34.2 of the *Mental Health Act*. It will be used to document your nomination of a near relative. Any questions you have about this form may be addressed to the director or staff of this facility.

The *Mental Health Act* requires that the director must send a notice to a near relative immediately after a patient's admission, discharge or an application to the review panel (where applicable).

If you do not name a near relative, the director must choose a near relative to be notified. If the director has no information about your relatives, notification will be sent to the Public Guardian and Trustee.

I, _____, would like the near relative named below
first and last name of patient (please print)
to be notified of my admission or discharge or an application to the review panel (as applicable).

Person to be notified:

_____ _____
first and last name *telephone number*

_____ _____
address *postal code*

This person's relationship to me is: (please check one only):

☐ wife	☐ husband	☐ common-law spouse	☐ committee of person
☐ mother	☐ father	☐ same-sex partner	
☐ grandmother	☐ grandfather	☐ friend	
☐ daughter	☐ son	☐ companion	
☐ sister	☐ brother	☐ legal guardian	
☐ half sister	☐ half brother	☐ caregiver	

_____ _____
signature of patient *date (dd / mm / yyyy)*

_____
name of designated facility

For office use only

☐ No known relative
☐ Patient declined to complete form

_____
staff signature

Date signed:
Standard: Required

RESOURCES:

https://healthymindslearning.ca/mha-toolkit-overview/