Coat of Arms. Government of Ontario.

Consent and Capacity Board

Form A - Application to the Board to Review a Finding of Incapacity under Subsection 32(1), 50(1) or 65(1) of the *Health Care Consent Act.*

Clear Form | Print Form

Section 1- Applicant (Patient/Resident)

Last Name	First Name
Reynen	Steven

Unit No.	Street No.	Street Name	PO Box
	1145	Carling Avenue	

City/Town	Province	Postal Code
Ottawa	ON	K1Z 7K4

Telephone No. (including area code)	Fax No.	Email Address
343-254-4590		reynen@pm.me

Section 2 - Application Type

I apply to the Board for a review of:

- [x] a health practitioner's finding that I am incapable of consenting to my treatment

Specify: _____

- [ ] an evaluator's finding that I am incapable of consenting to my admission to a Long Term Care Home
- [ ] an evaluator's finding that I am incapable of consenting to receiving personal assistance services in a Long Term Care or Retirement Home

Section 3 - Person Who Made the Finding of Incapacity

Note: An application may only be made if a health practitioner or evaluator has made a relevant finding of incapacity.

Last Name	First Name
Rogers	Tabitha

Unit No.	Street No.	Street Name	PO Box
	1145	Carling Avenue	

City/Town	Province	Postal Code
Ottawa	Ontario	K1Z 7K4

Telephone No. (including area code)	Fax No.	Email Address
613-727-6521		tabitha.rogers@theroyal.ca

Section 4 - Health Practitioner Who Proposed the Treatment

If this application refers to **treatment**, provide the contact information about the person proposing treatment.

- [x] Same as Section 3

Last Name	First Name
Rogers	Tabitha

Unit No.	Street No.	Street Name	PO Box
	1145	Carling Avenue	

City/Town	Province	Postal Code
Ottawa	Ontario	

Telephone No. (including area code)	Fax No.	Email Address
613-727-6521		tabitha.rogers@theroyal.ca

Section 5 - Person Responsible for Authorizing Admission to Long-Term Care

If this application refers to **admission to long term care**, provide the contact information about the person responsible for authorizing admissions to the facility. This will usually be a person from the Local Health Integration Network.

☐ Same as Section 3

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

Telephone No. (including area code)	Fax No.	Email Address

Section 6 - Person Responsible for Providing a Personal Assistance Service

If this application refers to a **personal assistance service**, this may be the person or organization that provides the service.

☐ Same as Section 3

Last Name	First Name

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

Telephone No. (including area code)	Fax No.	Email Address

Section 7 - Information About the Facility

Are you currently an in-patient or resident at a health or residential facility

☑ Yes, provide information about the facility ☐ No

Name of Facility	Ward
The Royal	Schizophrenia South

Unit No.	Street No.	Street Name	PO Box
	1145	Carling Avenue	

City/Town	Province	Postal Code
Ottawa	Ontario	K1Z 7K4

Contact Name (First Name, Last Name)	Telephone No. (including area code)	Fax No.
Steven Reynen	343-254-4590	

Section 8 - Person Who Will Represent the Applicant at the Hearing (e.g. lawyer)

Last Name	First Name
Reynen	Steven

Unit No.	Street No.	Street Name	PO Box
	1145	Carling Avenue	

City/Town	Province	Postal Code
Ottawa	Ontario	

Telephone No. (including area code)	Fax No.	Email Address
343-254-4590		

Section 9 - Other Information That Will Assist Us in Arranging the Hearing

Interpreter Required

☐ Yes ☑ No

Language

Accommodation required

☑ Yes ☐ No

Specify

I have ADHD, DID, GAD, and OCD Traits. My symptoms are also indicative of Schizoaffective Disorder, and it is possible I also have this diagnosis. I would appreciate the ability to recite my arguments without interruption. I will prepare them ahead of time and submit them to all parties as in my previous hearing.

Other Information

There has been a material change in circumstance since the previous hearing on August 27, 2025.
I now pass the test for capacity (per the binding ruling in the Supreme Court of Canada case STARSON v SWAYZE). I do not deny that I have a mental illness. I appreciate the reasonably foreseeable consequences of refusing treatment.

Date of Application (yyyy/mm/dd)

2025/10/27

Collection of this information is for the purpose of conducting a proceeding before this Board. It is collected/used for this purpose under the authority of subsection 32(1) / 50(1) / 65(1) of the *Health Care Consent Act*. For information about collection practices, contact the Board. Fax completed application to the Board at 1-866-777-7273 or send by email to ccb@ontario.ca. For assistance, call: 1-866-777-7391.