FORM 2 MENTAL HEALTH ACT

[Section 20, R.S.B.C. 1996, c. 288]

CONSENT FOR TREATMENT (VOLUNTARY PATIENT)

patient's first and last name (please print)	
name of designated facility	,
uthorize the following treatment(s)	
ne nature of my condition, options for my treatment, the reason be treatment(s) described above have been explained to me by	s for and the likely benefits and risks
name and position/title	
signature (patient, if 16 years of age or older)	date of signature (dd / mm / yyyy)
signature (parent or guardian, if patient is under 16 years of age)	date of signature (dd / mm / yyyy,
name of parent or guardian, if applicable (please print)	
hame of parent of guardian, if applicable (please pling	
signature (witness)	date of signature (dd / mm / yyyy,
first and last name of witness (please print)	