

FORM 2
MENTAL HEALTH ACT
[Section 20, R.S.B.C. 1996, c. 288]

CONSENT FOR TREATMENT
(VOLUNTARY PATIENT)

I, _____,
patient's first and last name (please print)

in _____
name of designated facility

authorize the following treatment(s) _____

Note: if above space is insufficient, continue on back of form

The nature of my condition, options for my treatment, the reasons for and the likely benefits and risks of the treatment(s) described above have been explained to me by

name and position/title

signature (patient, if 16 years of age or older)

date of signature (dd / mm / yyyy)

or

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)

signature (witness)

date of signature (dd / mm / yyyy)

first and last name of witness (please print)