CONSENT FOR TREATMENT
(INVOLUNTARY PATIENT)

Note: Complete either A or B

A. I, __________________________ , authorize the treatment described below.

  
  __________________________
  first and last name of patient (please print)

B. I, __________________________ , authorize the treatment described below

  with respect to __________________________ at __________________________.

  __________________________
  first and last name of patient
  __________________________
  name of designated facility (please print)

Description of treatment/course of treatment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment described above have been explained to me by __________________________.

  __________________________
  name and position/title

Complete either A or B

A. If signed by patient

  __________________________
  patient’s signature

  __________________________
  date (dd / mm / yyyy)  time

  __________________________
  witness’ signature

  __________________________
  witness’ first and last name (please print)

B. If not signed by patient

  __________________________
  signature

  __________________________
  name of director or person authorized by the director (please print)

  __________________________
  position/title

  __________________________
  date (dd / mm / yyyy)  time

The above-named patient is an involuntary patient under section 22, 28, 29, 30, or 42 of the Mental Health Act and to the best of my judgment is incapable of appreciating the nature of treatment and/or his or her need for it, and is therefore incapable of giving consent.

  __________________________
  signature of physician
  M.D.

  __________________________
  signature of physician
  M.D.