

**FORM 5**  
**MENTAL HEALTH ACT**  
[ Sections 8 and 31, R.S.B.C. 1996, c. 288 ]

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

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)*

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

\_\_\_\_\_, M.D.  
*signature of physician*

**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.

\_\_\_\_\_, M.D.  
*signature of physician*