FORM 5
MENTAL HEALTH ACT
[Section 8, 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 the patient's need for it, and is therefore incapable of giving consent.

_____ , M.D.
signature of physician

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