BC MENTAL HEALTH ACT

CONSENT FOR TREATMENT FORM 5 QUICK GUIDE

1. DESCRIPTION OF TREATMENT

CONSENT IS ONLY FOR PSYCHIATRIC TREATMENT

MAY include:

- Medication or class(es) of medication prescribed, outlining the target symptoms
- Feeding for those patients diagnosed with an eating disorder
- Screening bloodwork for psychiatric diagnoses
- Monitoring bloodwork for psychotropic drug levels or metabolic panels
- Studies related to diagnostic clarification (EEG, CT, MRI)
- Cardiograms in advance of/follow-up after initiating psychotropic medication
- Specific non-pharmacological therapeutic approaches
- Description of de-escalation process, outlining the target behaviours

Medical treatment related to self-injury is not included and needs to be consented to separately under the *Infants Act*.

Form 5 must be completed as soon as possible and no later then 24 hours from admission. While Form 5 does not expire, a new Form 5 must be completed every time there is a Significant Change in Treatment.

2. FORM COMPLETION

(See reverse for a sample Form 5)

1. **The designated facility name must be written out in full.**
   E.g. BC Children's Hospital (not BCCH)
2. **For required printed names: either full first and last name or first initial and last name.**
   E.g. George Jones or G. Jones
3. **A title may be abbreviated if it is a regulated health profession.**
   E.g. Regulated - Registered Nurse: RN
   E.g. Not regulated - Clinical Nurse Coordinator: CNC
4. **Patient name on forms should be consistent with what is present on the most recent Form 4.**

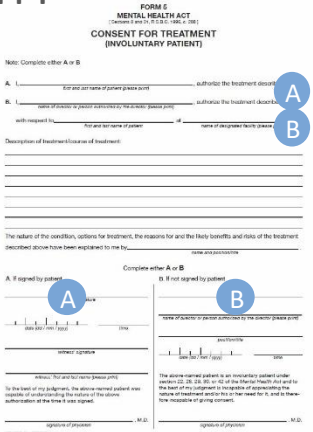
The treatment description must be:

- Patient-specific and meaningful
- In plain language
- Include all psychiatric treatments the patient can expect to undergo
- Follow trauma-informed principles

3. ASSESSING CAPACITY

A If the patient has capacity and is willing to sign Form 5, section A is completed.

B If the patient does not have capacity or refuses to sign Form 5, section B is completed by the director/ delegate.


FORM 5
MENTAL HEALTH ACT
CONSENT FOR TREATMENT
(INVOLUNTARY PATIENT)

4. FURTHER RESOURCES

- https://healthymindslearning.ca/mha-toolkit-overview/
- http://policyandorders.cw.bc.ca/

BC Children's Hospital Provincial Health Services Authority

BC WOMEN'S HOSPITAL+ HEALTH CENTRE Provincial Health Services Authority

EXAMPLE FOR LEARNING PURPOSES ONLY

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, Jamie Smith (*first and last name of patient (please print)*), authorize the treatment described below.

B. I, _____ (*name of director or person authorized by the director (please print)*), authorize the treatment described below

with respect to _____ (*first and last name of patient*) at _____ (*name of designated facility (please print)*).

Description of treatment/course of treatment:

- Monitor for safety and progress further into illness.
- Gather more information (e.g. talk to parents).
- Baseline electrocardiogram prior to trialing antipsychotic meds.
- Basic medical blood work including psychotropic drug levels and metabolic panels.
- Therapeutic approach: crisis stabilization, family support and psychoeducation.
- For agitation, the de-escalation process to include verbal (for mild/moderate), Ativan &/or Loxapine (for severe; as needed). Use of seclusion and/or restraint as a last resort for severe aggression.
- Monitor food ins and outs.

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 Dr. John Wilson, M.D. (*name and position/title*) (Treating Physician; may be psychiatric resident. Plus title).

DON'T FORGET!

Complete either **A** or **B**

A. If signed by patient

Jamie Smith
patient's signature

0 2 | 0 3 | 2 0 | 2 0 (*date (dd / mm / yyyy)*) 09:40 (*time*)

Sam Taylor
witness' signature

Sam Taylor (e.g. bedside nurse)
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.

Dr. Wilson (Treating physician), 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

HLTH 3505 Rev. 2005/06/01

EXAMPLE FOR LEARNING PURPOSES ONLY

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, _____ (first and last name of patient (please print)), authorize the treatment described below.

B. I, Rory Johnson (Director or delegate, not treating physician) (name of director or person authorized by the director (please print)), authorize the treatment described below

with respect to Jamie Smith (first and last name of patient) at BC Children's Hospital (name of designated facility (please print)).

Description of treatment/course of treatment:

- Monitor for safety and progress further into illness.
- Gather more information (e.g. talk to parents).
- Baseline electrocardiogram prior to trialing antipsychotic meds.
- Basic medical blood work including psychotropic drug levels and metabolic panels.
- Therapeutic approach: crisis stabilization, family support and psychoeducation.
- For agitation, the de-escalation process to include verbal (for mild/moderate), Ativan &/or Loxapine (for severe; as needed). Use of seclusion and/or restraint as a last resort for severe aggression.
- Monitor food ins and outs.

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 Dr. John Wilson, M.D. (Treating physician; may be psychiatric resident. . Plus title) (name and position/title)

DON'T FORGET!

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

Rory Johnson (Director or delegate, not treating physician) (signature)

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

Clinical Nurse Coordinator (position/title)

02 03 2020 (date (dd / mm / yyyy)) 09:40 (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.

Dr. Wilson (Treating physician) , M.D. (signature of physician)

HLTH 3505 Rev. 2005/06/01