



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

NOTICE TO DESIGNATED CARER OR PRINCIPAL CARE PROVIDER OF OTHER THAN INVOLUNTARY PATIENT OF APPLICATION TO DETERMINE VALIDITY OF ECT CONSENT

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

NSW MINISTRY OF HEALTH

MENTAL HEALTH ACT 2007

Sections 78 and 93

Dear

Notification of application to determine validity of consent to electro convulsive therapy - persons other than involuntary patients

It is my opinion as an authorised medical officer of
[name of mental health facility]

that it is desirable and in the best interests of
[full name of patient]

for him or her to undergo a course of electro convulsive therapy. He or she has consented. However, I am unsure whether he or she is capable of giving informed consent to the treatment.

In such cases I am required by law to notify you that an application is being made to the Mental Health Review Tribunal to determine whether he or she is capable of giving informed consent and has given that consent.

The Tribunal will conduct a hearing in relation to this application and you are able to attend if you wish.

If you wish to discuss this matter further please contact
[Name]

..... on
[telephone number]

Yours faithfully

Print name _____ Designation _____

Signature _____ Date ____ / ____ / ____



SMR025190

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING