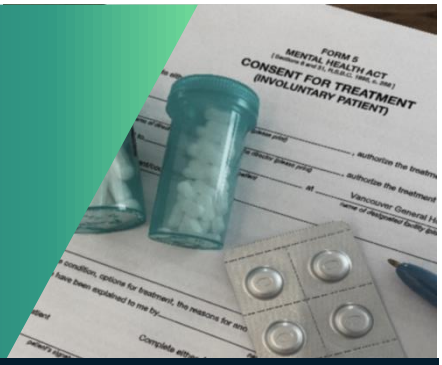
BC *Mental Health Act* Quick Guide

FORM 5

Consent for Treatment



Complete prior to involuntary psychiatric treatment. Failure to do so could lead to legal liability.

Cannot be used for medical/surgical (non-psychiatric) treatment. Use the *Health Care (Consent) and Care Facility (Admission) Act.*

1. Complete Description of Treatment

Description of treatment MUST:

- Include all **psychiatric** treatments the patient can expect to undergo (including **observation, sedation, seclusion/restraint**).
- Have **all medications** listed by class or indication.
- Be patient specific, in plain language and written legibly.
- Follow trauma-informed principles.

- A new Form 5 must be completed **every time** there is a **significant change in treatment:** e.g. ECT or Clozapine initiation, new class of medications, seclusion/restraint, transfers to a new Designated Facility.
- A new Form 5 is **not** required for transfers between units in the same facility.

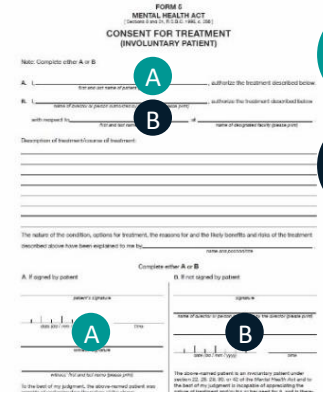
Physician Only

Description of Treatment is completed by a **physician** who is fully licensed to practice in BC.

The physician must have personally examined the patient.

CST Cerner Designated Facilities:
Complete electronic Form 5 in "PDF Forms" page and ensure one of your area's Director/Delegate co-signs the form.

2. Co-sign Section A or Section B



A — If the patient is willing to sign Form 5, Section A is completed.

B — If the patient is unable or declines to sign Form 5, Section B is completed by the Director/Delegate.

Director/Delegate reviews treatment plan and ensures it only includes psychiatric treatment before co-signing.

Section A: Patient or Section B: Director/Delegate

Director/Delegate requirement: Full first and last name.

Ideally, another physician signs Part B. However, if an eligible physician is not available to sign, the following clinicians may sign in order of preference:

Specialized Psychiatric Nurse Clinician, Patient Care (or Services) Manager, Care Management Leader, Unit Nurse-in-Charge.

A title may be abbreviated if it is a regulated health profession: E.g. Nurse: RPN, RN; Physician: Dr.

Learn More

- Decision Support Tool – Involuntary Admissions under MH Act (from SHOP)
- MH Act Authorization Matrix
- BC MH Act Learning Hub Course
- *Provincial Standards for Operators and Directors of Designated Facilities*
- Guide to the MH Act

Reminder: Forms 13, 15, 16 must be completed as soon as possible, within 24 hours of involuntary admission.

Guide created by VCH & PHC Involuntary Admissions Support Team.
Aug 2023: 1/3

Vancouver Coastal Health | Providence Health Care — How you want to be treated.

EXAMPLE FOR LEARNING PURPOSES ONLY

SCENARIO A:
Patient agrees to sign Form 5 – Completion of Section A

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

CONSENT FOR TREATMENT (INVOLUNTARY PATIENT)

Do **not** place patient label over name

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:

Diagnosis: Mood Disorder

Mood stabilizers, Antipsychotics, Benzodiazepines

Bloodwork, urine drug screen, to rule out medical etiology of psychiatric symptoms and monitor serum lithium levels

Use of seclusion and/or restraint as a last resort for severe agitation

Treating Physician MUST have conversation with patient about benefits and risks 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 Dr. John Wilson, M.D. (name and position/title).

Treating Physician **MUST** include:
- ✓ Full name or first initial and last name
- ✓ Designation

The description of treatment must be:
- ✓ Patient specific and meaningful
- ✓ In plain language
- ✓ Include all psychiatric treatments the patient can expect to undergo, such as:
  - Observation
  - Restraints or seclusion as a last resort for severe agitation with indication specific to patient
- ✓ Follow trauma-informed principles
- ✓ Any medications included listed by class or indication, such as:
  - Benzodiazepines as required
  - Antipsychotics as required
  - Anxiolytics/Sedatives/Hypnotics as required
  - Benztropine as required
- ✓ Written legibly (e.g. written in print)

A. If signed by patient

Jamie Smith
patient's signature

0 1 | 0 3 | 2 0 2 1 — 09:40
date (dd / mm / yyyy) — *time*

Sam Taylor
witness' signature

E.g. Bedside nurse

Sam Taylor
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
signature of physician

Treating Physician signature **MUST** be included

B. If not sig… **A** or **B**

_____
name of dire…

_____
date

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

SCENARIO B:
Patient declines or is unable to sign Form 5 – Completion of Section B

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

CONSENT FOR TREATMENT
(INVOLUNTARY PATIENT)

Do **not** place patient label over name

Note: Complete either **A** or **B**

Director/Delegate name **MUST** include:
- ✓ Full first and last name
- ✓ Not the treating physician*

Director/Delegate in order of preference:
Another Physician, Psychiatric Triage Nurse, Patient Care (or Services) Manager, Care Management Leader, Unit Nurse-in-Charge

A. I, _____, auth… …eatment described below.
first and last name of patient (please print)

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

with respect to Jamie Smith at VGH
first and last name of patient *name of designated facility (please print)*

Commonly used abbreviations of hospital names are acceptable

Description of treatment/course of treatment:

Diagnosis: Mood Disorder

Mood stabilizers, Antipsychotics, Benzodiazepines

Bloodwork, urine drug screen, to rule out medical etiology of psychiatric symptoms and monitor serum lithium levels

Use of seclusion and/or restraint as a last resort for severe agitation

Treating Physician MUST have conversation with patient about benefits and risks of treatment.

The nature of the condition, options for tre…ent, the reasons for and the likely benefits and risks of the treatment described above have been explained … by Dr. John Wilson, M.D.
name and position/title

Treating Physician **MUST** include:
- ✓ Full name or first initial and last name
- ✓ Designation

The description of treatment must be:
- ✓ Patient specific and meaningful
- ✓ In plain language
- ✓ Include all psychiatric treatments the patient can expect to undergo, such as:
  - Observation
  - Restraints or seclusion as a last resort for severe agitation with indication specific to patient
- ✓ Follow trauma-informed principles
- ✓ Any medications included listed by class or indication, such as:
  - Benzodiazepines as required
  - Antipsychotics as required
  - Anxiolytics/Sedatives/Hypnotics as required
  - Benztropine as required
- ✓ Written legibly (e.g. written in print)

…e either **A** or **B**

B. If not signed by patient

Rory Johnson
signature

Director/Delegate, NOT treating physician. **MUST** be identical to field above

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

Unit Nurse-in-Charge
position/title

0 1 | 0 3 | 2 0 2 1 — 09:40
date (dd / mm / yyyy) *time*

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.

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.

Treating Physician signature **MUST** be included

_____
signature of physician

Dr. Wilson, M.D.
signature of physician

HLTH 3505 Rev. 2005/06/01