



FAMILY NAME

MRN

GIVEN NAME

MALE  FEMALE

Facility:

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

M.O.

ADDRESS

**NOTICE TO DESIGNATED CARER OR PRINCIPAL CARE PROVIDER OF AN INVOLUNTARY PATIENT OF APPLICATION TO MENTAL HEALTH REVIEW TRIBUNAL FOR CONSENT TO ECT**

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**NSW MINISTRY OF HEALTH  
MENTAL HEALTH ACT 2007  
Sections 78 and 94**

Dear .....

Address .....

**Notification of application to administer electro convulsive therapy - 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 .....  
(patient's full name)

for him/her to undergo a course of electro convulsive therapy.

The patient:

- has consented to the treatment
- is incapable of giving consent to the treatment
- is capable of giving consent to the treatment but has refused to do so
- is capable of giving consent to the treatment but has neither refused nor consented.

**(Tick one box only)**

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:

- (a) whether the patient is capable of giving informed consent to the administration of the treatment and has given that consent; and
- (b) if the patient is incapable of giving informed consent or has not consented - whether the treatment is necessary or desirable for the safety or welfare of the patient.

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

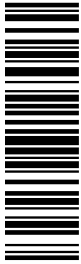
If you wish to discuss this matter further please contact .....

..... on .....  
(name) (telephone number)

Yours faithfully

Print name ..... Designation .....  
(Authorised medical officer)

Signature: ..... Date: ...../...../.....



SMR025185

Holes Punched as per AS2828.1: 2012  
BINDING MARGIN - NO WRITING

NH608717A 240915

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SMR025.185