NSW GOVERNMENT Health

**Facility:**

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

| | |
|---|---|
| FAMILY NAME | MRN |
| GIVEN NAME | ☐ MALE ☐ FEMALE |
| D.O.B. _____ / _____ / _____ | M.O. |
| ADDRESS | |
| | |
| LOCATION | |

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR025190

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NSW MINISTRY OF HEALTH

**MENTAL HEALTH ACT 2007**

Sections 78 and 93

Dear .....

Address .....

.....

**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 ..... / ..... / .....

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SMR025.190