FORM 11
MENTAL HEALTH ACT
[Section 31, R.S.B.C. 1996, c. 288]

REQUEST FOR SECOND MEDICAL OPINION

I, _____ , request a second medical opinion
first and last name (please print)

Note: check one box only

☐ on the appropriateness of my treatment.

OR

☐ on the appropriateness of the treatment of _____
first and last name of patient

who is an involuntary patient at _____ .
name of designated facility

Note: Complete either 1 or 2

1. Request for a specific physician

I request the examination be carried out by Dr. _____

of _____ .
address of physician (if known)

If my first choice is not available, I request Dr. _____

of _____ .
address of physician (if known)

I confirm that I have been advised that there may be a cost to me depending upon the distance the physician has to travel.

OR

2. Request to director to appoint a physician

I request that the director appoint a physician to conduct the examination.

_____ _____
signature *date (dd / mm / yyyy)*

_____ _____
signature of witness *name of witness (please print)*

_____
address and phone number (if applying on behalf of the patient)

PRINT CLEAR FORM