

THIS FORM IS NOT TO BE USED FOR PATIENTS UNDER 18 YEARS OF AGE

I (*PRINT full name and address*)

the approved clinician in charge of the treatment described below / a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD) (*delete as appropriate*) certify that

(*PRINT full name and address of patient*)

who has attained the age of 18 years,

(a) is capable of understanding the nature, purpose and likely effects of: (*Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.*)

(*If you need to continue on a separate sheet please indicate here () and attach that sheet to this form*)

AND

(b) has consented to that treatment.

Signed

Date

/ /