MENTAL HEALTH ACT, 2012
FOURTEENTH SCHEDULE
[Article 33(2)(b)]

Part II

Mental Health Act	This application shall be submitted to the Commissioner. IIT Ref No:
APPLICATION FOR INVASIVE OR IRREVERSIBLE TREATMENT	
To the Commissioner for the Promotion of Rights of Persons with Mental Disorders.	
To be filled by responsible specialist in mental health.	(1) Please approve my request in respect of: __________ __________ __________ __________ M / F ______ (Surname) (Name) (ID No) (D.O.B) (Sex) (Ward) of (address) ____ ____ To undergo invasive or irreversible treatment for his/her mental disorder. (2) If applicable, indicate if person is: □ a voluntary patient _________ □ an involuntary patient under an Involuntary Admission for Observation IAO Ref No _________ □ an involuntary patient under an Involuntary Admission for Treatment Order IATO Ref No ________ □ an involuntary patient under an Extension of Involuntary Admission for Treatment Order EIATO Ref No ________ □ an involuntary patient under a Continuing Detention Order CDO Ref No _________ □ an involuntary patient under a Community Treatment Order CTO Ref No ________ (3) Specify treatment to be given ____ ____ (4) Treatment is to be performed by ______________________________ (5) I certify that: • the patient has the mental capacity to give, and has given, informed consent to undergo such treatment; • the consent is in writing and signed by the person (copy attached); • there is sufficient evidence-based knowledge about this treatment; • the treatment benefits the health needs of the patient; • every available alternative treatment that could reasonably be regarded as likely to produce a sufficient and lasting benefit has been given to this patient without a sufficient and lasting benefit.

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(6) Attached is a clinical report on the recommended treatment including the:

- **patient's treatment history;**
- **proposed treatment;**
- **reasons for such treatment;**
- **evidence-based knowledge about this treatment; and**
- **benefits for this patient.**

(Official Stamp) ____________ **(Signature)** ____________ **(Reg. No)** ____________

(Date) ____________ **(Time)** ____________

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To be filled by Commissioner

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Application received on (date) ____________________

Action

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Comments

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Decision

□ Treatment approved

□ Treatment not approved

My decision was communicated in writing to the responsible specialist on (date) _______________

(Signature) ____________ **(Official Stamp)** ____________ **(Date)** ____________ **(Time)** ____________

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