

**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)*