FORM 12
MENTAL HEALTH ACT
[Section 31, R.S.B.C. 1996, c. 288]

MEDICAL REPORT
(SECOND MEDICAL OPINION)

To the director of _____ :
name of designated facility

On ___ ___ ___ I examined _____
date (dd / mm / yyyy) *first and last name of patient (please print)*

who is a patient at _____ .
name of designated facility

Based on my examination, my opinion on the appropriateness of the treatment is
(include recommendations if any):

_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

Note: If above space is insufficient, continue on back of form

_____ ___ ___ ___
physician's signature *date (dd / mm / yyyy)*

_____
physician's name (please print)

_____
physician's address and phone number

For Office Use Only

☐ I acknowledge receipt of this medical report.

_____ ___ ___ ___
signature of director *date (dd / mm / yyyy)*