

THIS FORM IS ONLY TO BE USED FOR PATIENTS UNDER 18 YEARS OF AGE

I (*PRINT full name, address and, if sending by means of electronic communication, email address*)

a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD)
certify that

(*PRINT full name and address of patient*)

who has not yet 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.

continue overleaf

In my opinion it is appropriate for that treatment to be given.

My reasons are as below / I will provide a statement of my reasons separately. (*Delete as appropriate*)

(When giving reasons please indicate if, in your opinion, disclosure of the reasons to the patient would be likely to cause serious harm to the physical or mental health of the patient, or to that of any other person.)

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

Signed

Date

/		/
---	--	---