SCHEDULE 1 Regulations 4-9,13-17, 25, 27 and 28

FORMS FOR USE IN CONNECTION WITH COMPULSORY ADMISSION TO HOSPITAL, GUARDIANSHIP AND TREATMENT

Form A1Mental Health Act 1983 section 2—application by nearest relative for admission for assessment

Regulation 4(1)(a)(i)

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for assessment in accordance with Part 2 of the Mental Health Act 1983.

Complete (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Act.

I am the patient's [state your relationship with the patient].

(b) I have been authorised to exercise the functions under the Act of the patient's nearest relative by a county court/the patient's nearest relative <*delete the phrase which does not apply*>, and a copy of the authority is attached to this application.

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

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.....

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

Signed.....

Date.....

Form A2Mental Health Act 1983 section 2—application by an approved mental health professional for admission for assessment

Regulation 4(1)(a)(ii)

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for assessment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [PRINT name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by <*delete as appropriate*>

that authority
[name of local social services authority that approved you, if different]

Complete the following if you know who the nearest relative is.

Complete (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief [PRINT full name and address] is the patient's nearest relative within the meaning of the Act.

(b) I understand that [PRINT full name and address] has been authorised by a county court/the patient's nearest relative* to exercise the functions under the Act of the patient's nearest relative.
<**Delete the phrase which does not apply*>

I have/have not yet* informed that person that this application is to be made and of the nearest relative's power to order the discharge of the patient. <**Delete the phrase which does not apply*>

Complete the following if you do not know who the nearest relative is.

Delete (a) or (b).

(a) I have been unable to ascertain who is the patient's nearest relative within the meaning of the Act.

(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

The remainder of the form must be completed in all cases.

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

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……

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

Signed……
Date ……

Form A3Mental Health Act 1983 section 2—joint medical recommendation for admission for assessment

Regulation 4(1)(b)(i)

We, registered medical practitioners, recommend that [PRINT full name and address of patient] be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I [PRINT full name and address of first practitioner] last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

<*Delete if not applicable*>

I [PRINT full name and address of second practitioner] last examined this patient on [date].

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

<*Delete if not applicable*>

In our opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

(b) ought to be so detained
  (i) in the interests of the patient's own health
  (ii) in the interests of the patient's own safety
  (iii) with a view to the protection of other persons.
  <*Delete the indents not applicable*>

Our reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.]

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……

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

Signed……
Date……
Signed……
Date……

NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.

Form A4Mental Health Act 1983 section 2—medical recommendation for admission for assessment

Regulation 4(1)(b)(ii)

I [PRINT full name and address of medical practitioner], a registered medical practitioner, recommend that [PRINT full name and address of patient] be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date].

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
<*Delete if not applicable*>

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

(b) ought to be so detained
(i) in the interests of the patient's own health
(ii) in the interests of the patient's own safety
(iii) with a view to the protection of other persons.
<*Delete the indents not applicable*>

My reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.]

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

Signed.....
Date.....

Form A5Mental Health Act 1983 section 3— application by nearest relative for admission for treatment

Regulation 4(1)(c)(i)

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for treatment in accordance with Part 2 of the Mental Health Act 1983.

Complete either (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Act.

I am the patient's [state your relationship with the patient].

(b) I have been authorised to exercise the functions under the Act of the patient's nearest relative by a county court/the patient's nearest relative <*delete the phrase which does not apply*>, and a copy of the authority is attached to this application.

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making the recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

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

Signed.....
Date.....

Form A6Mental Health Act 1983 section 3—application by an approved mental health professional for admission for treatment

Regulation 4(1)(c)(ii)

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for treatment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by <*delete as appropriate*>

that authority
[name of local social services authority that approved you, if different]

Complete the following where consultation with the nearest relative has taken place.

Complete (a) or (b) and delete the other.

(a) I have consulted [PRINT full name and address] who to the best of my knowledge and belief is the patient's nearest relative within the meaning of the Act.

(b) I have consulted [PRINT full name and address] who I understand has been authorised by a county court/the patient's nearest relative* to exercise the functions under the Act of the patient's nearest relative.
<**Delete the phrase which does not apply*>

That person has not notified me or the local social services authority on whose behalf I am acting that he or she objects to this application being made.

Complete the following where the nearest relative has not been consulted.

Delete whichever two of (a), (b) and (c) do not apply.

(a) I have been unable to ascertain who is this patient's nearest relative within the meaning of the Act.

(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

(c) I understand that [PRINT full name and address] is
(i) this patient's nearest relative within the meaning of the Act,
(ii) authorised to exercise the functions of this patient's nearest relative under the Act,<*Delete either (i) or (ii)*>

but in my opinion it is not reasonably practicable/would involve unreasonable delay <*delete as appropriate*> to consult that person before making this application, because—

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……
……

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

The remainder of this form must be completed in all cases.

I saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

I have interviewed the patient and l am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

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……
If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed……
Date……

Form A7Mental Health Act 1983 section 3—joint medical recommendation for admission for treatment

Regulation 4(1)(d)(i)

We, registered medical practitioners, recommend that [PRINT full name and address of patient] be admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I [PRINT full name and address of first practitioner] last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
<**Delete if not applicable*>

I [PRINT name and address of second practitioner]

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
<**Delete if not applicable*>

In our opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
  (i) for the patient's own health
  (ii) for the patient's own safety
  (iii) for the protection of other persons
  <*delete the indents not applicable*>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained under section 3 of the Act,

because — [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]

……..
……..
……..

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

……..

We are also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):-

[Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.]

……..
……..
……..

Signed……
Date……

Signed……
Date……

NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.

Form A8Mental Health Act 1983 section 3—medical recommendation for admission for treatment

Regulation 4(1)(d)(ii)

I [PRINT full name and address of practitioner], a registered medical practitioner, recommend that [PRINT full name and address of patient] be admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
<**Delete if not applicable*>

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
(i) for the patient's own health
(ii) for the patient's own safety
(iii) for the protection of other persons
<*delete the indents not applicable*>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained under section 3 of the Act,

because — [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]

……..
……..
……..

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

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):—

……..
……..

[Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.]

Signed……
Date……

Form A9Mental Health Act 1983 section 4—emergency application by nearest relative for admission for assessment

Regulation 4(1)(e)(i)

THIS FORM IS TO BE USED ONLY FOR AN EMERGENCY APPLICATION

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for assessment in accordance with Part 2 of the Mental Health Act 1983.

Complete (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Act.

I am the patient's [state your relationship with the patient].

(b) I have been authorised to exercise the functions under the Act of the patient's nearest relative by a county court/the patient's nearest relative <*delete the phrase which does not apply*>, and a copy of the authority is attached to this application.

I last saw the patient on [date], which was within the last 24 hours.

In my opinion it is of urgent necessity for the patient to be admitted and detained under section 2 of the Act and compliance with the provisions of Part 2 of the Act relating to applications under that section would involve undesirable delay.

This application is founded on a medical recommendation in the prescribed form.

If the medical practitioner did not have previous acquaintance with the patient before making the recommendation, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

……..
……..
……..

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

Signed……
Date……
Time……..

Form A10Mental Health Act 1983 section 4—emergency application by an approved mental health professional for admission for assessment

Regulation 4(1)(e)(ii)

THIS FORM IS TO BE USED ONLY FOR AN EMERGENCY APPLICATION

To the managers of [name and address of hospital]

I [PRINT your full name and address] apply for the admission of [PRINT full name and address of patient] for assessment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by <*delete as appropriate*>

that authority
[name of local social services authority that approved you, if different].

I last saw the patient on [date] at [time], which was within the last 24 hours.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

In my opinion it is of urgent necessity for the patient to be admitted and detained under section 2 of the Act and compliance with the provisions of Part 2 of the Act relating to applications under that section would involve undesirable delay.

This application is founded on a medical recommendation in the prescribed form.

If the medical practitioner did not have previous acquaintance with the patient before making the recommendation, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

……..
……..
……..

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

Signed……
Date……
Time……..

Form A11Mental Health Act 1983 section 4—medical recommendation for emergency admission for assessment

Regulation 4(1)(f)

THIS FORM IS TO BE USED ONLY FOR AN EMERGENCY APPLICATION

I [PRINT name and address of medical practitioner], a registered medical practitioner, recommend that [PRINT full name and address of patient] be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date] at [time].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.
<**Delete if not applicable*>

I am of the opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

(b) this patient ought to be so detained
(i) in the interests of the patient's own health
(ii) in the interests of the patient's own safety
(iii) with a view to the protection of other persons,
<*delete the indents not applicable*>

AND

(c) it is of urgent necessity for the patient to be admitted and detained under section 2 of the Act.

My reasons for these opinions are: [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient ought to be admitted to hospital urgently and why informal admission is not appropriate.]

……..
……..
……..

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

Compliance with the provisions of Part 2 of the Act relating to applications under section 2 would involve undesirable delay, because— [Say approximately how long you think it would take to obtain a second medical recommendation and what risk such a delay would pose to the patient or to other people.]

……..
……..

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

Signed……
Date……
Time……..

Form H1Mental Health Act 1983 section 5(2)—report on hospital in-patient

Regulation 4(1)(g)

PART 1
(To be completed by a medical practitioner or an approved clinician qualified to do so under section 5(2) of the Act)

To the managers of [name and address of hospital]

I am [PRINT full name]

and I am <*Delete (a) or (b) as appropriate*>

(a) the registered medical practitioner/the approved clinician (who is not a registered medical practitioner)<*delete the phrase which does not apply*>

(b) a registered medical practitioner/an approved clinician (who is not a registered medical practitioner)* who is the nominee of the registered medical practitioner or approved clinician (who is not a registered medical practitioner) <**delete the phrase which does not apply*>

in charge of the treatment of [PRINT full name of patient], who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983.

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons—

……..
……..
……..

[The full reasons why informal treatment is no longer appropriate must be given. If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form.]

I am furnishing this report by: <*Delete the phrase which does not apply*>

consigning it to the hospital managers' internal mail system today at [time]

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed……
Date……

PART 2
(To be completed on behalf of the hospital managers)

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system

delivered to me in person as someone authorised by the hospital managers to receive this report at [time] on [date]

Signed……..
on behalf of the hospital managers
PRINT NAME……
Date……

Form H2Mental Health Act 1983 section 5(4)—record of hospital in-patient

Regulation 4(1)(h)

To the managers of [name and address of hospital]

[PRINT full name of the patient]

It appears to me that—

(a) this patient, who is receiving treatment for mental disorder as an in-patient of this hospital, is suffering from mental disorder to such a degree that it is necessary for the patient's health or safety or for the protection of others for this patient to be immediately restrained from leaving the hospital;

AND

(b) it is not practicable to secure the immediate attendance of a registered medical practitioner or an approved clinician (who is not a registered practitioner) for the purpose of furnishing a report under section 5(2) of the Mental Health Act 1983.

I am [PRINT full name], a nurse registered—

<Delete whichever do not apply>

(a) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing;

(b) in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing;

(c) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing;

(d) in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing.

Signed……
Date……
Time……..

Form H3Mental Health Act 1983 sections 2, 3 and 4—record of detention in hospital

Regulation 4(4) and (5)

(To be attached to the application for admission)

PART 1

[Name and address of hospital]

[PRINT full name of patient]

Complete (a) if the patient is not already an in-patient in the hospital.

Complete (b) if the patient is already an in-patient.

Delete the one which does not apply.

(a) The above named patient was admitted to this hospital on [date of admission to hospital] at [time] in pursuance of an application for admission under section [state section] of the Mental Health Act 1983.

(b) An application for the admission of the above named patient (who had already been admitted to this hospital) under section [state section] of the Mental Health Act 1983 was received by me on behalf of the hospital managers on [date] at [time] and the patient was accordingly treated as admitted for the purposes of the Act from that time.

Signed……..
on behalf of the hospital managers
PRINT NAME……
Date……

PART 2

(To be completed only if the patient was admitted in pursuance of an emergency application under section 4 of the Act)

On [date] at [time] I received, on behalf of the hospital managers, the second medical recommendation in support of the application for the admission of the above named patient.

Signed……..
on behalf of the hospital managers
PRINT NAME……
Date……

NOTE: IF THE PATIENT IS BEING DETAINED AS A RESULT OF A TRANSFER FROM GUARDIANSHIP, THE PATIENT'S ADMISSION SHOULD BE RECORDED IN PART 2 OF THE FORM G8 WHICH AUTHORISED THE TRANSFER.

Form H4Mental Health Act 1983 section 19—authority for transfer from one hospital to another under different managers

Regulation 7(2)(a) and 7(3)

PART 1

(To be completed on behalf of the managers of the hospital where the patient is detained)

Authority is given for the transfer of [PRINT full name of patient] from [name and address of hospital in which the patient is liable to be detained] to [name and address of hospital to which patient is to be transferred] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 within 28 days beginning with the date of this authority.

Signed……
on behalf of the managers of the first named hospital
PRINT NAME……
Date……..

PART 2

RECORD OF ADMISSION

(This is not part of the authority for transfer but is to be completed at the hospital to which the patient is transferred)

This patient was transferred to [name of hospital] in pursuance of this authority for transfer and admitted to that hospital on [date of admission to receiving hospital] at [time].

Signed……
on behalf of the managers of the receiving hospital
PRINT NAME……
Date……..

Form H5Mental Health Act 1983 section 20—renewal of authority for detention

Regulation 13(1), (2) and (3)

PART 1

(To be completed by the responsible clinician)

To the managers of [name and address of hospital in which the patient is liable to be detained]

I examined [PRINT full name of patient] on [date of examination].

The patient is liable to be detained for a period ending on [date authority for detention is due to expire].

I have consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
  (i) for the patient's own health
  (ii) for the patient's own safety
  (iii) for the protection of other persons
<delete the indents not applicable>

that this patient should receive treatment in hospital,

because— [Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate.]

.....
.....
.....

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

Such treatment cannot be provided unless the patient continues to be detained under the Act, for the following reasons — [Reasons should indicate why informal admission is not appropriate.]

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.....
.....

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form.]

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient.

Signed……
PRINT NAME……
Profession……
Date……..……...

PART 2

(To be completed by a professional who has been professionally concerned with the patient's medical treatment and who is of a different profession from the responsible clinician)

I agree with the responsible clinician that: this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital; it is necessary for the patient's own health or safety or for the protection of other persons that the patient should receive treatment and it cannot be provided unless the patient continues to be detained under the Act; and that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

Signed……
PRINT NAME……
Profession……
Date……..……...

PART 3

(To be completed by the responsible clinician)

I am furnishing this report by: <*Delete the phrase which does not apply*>

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed……
PRINT NAME……
Date……..……...

PART 4

(To be completed on behalf of the hospital managers)

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers on [date].

Signed……
on behalf of the hospital managers
PRINT NAME……
Date……..……

Form H6Mental Health Act 1983 section 21B—authority for detention after absence without leave for more than 28 days

Regulation 14(1)(a) and (b)

PART 1
(To be completed by the responsible clinician)

To the managers of [name and address of hospital in which the patient is liable to be detained]

I examined [PRINT full name of patient] on [date of examination] who:

(a) was absent without leave from hospital or the place where the patient ought to have been beginning on [date absence without leave began];

(b) was/is* liable to be detained for a period ending on [date authority for detention would have expired, apart from any extension under section 21, or date on which it will expire]; <**delete the phrase which does not apply*> and

(c) returned to the hospital or place on [date].

I have consulted [PRINT full name of approved mental health professional] who is an approved mental health professional.

I have also consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary
- (i) for the patient's own health
- (ii) for the patient's own safety
- (iii) for the protection of other persons

<*delete the indents not applicable*>

that this patient should receive treatment in hospital,

because— [Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate.]

……
……
……

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

Such treatment cannot be provided unless the patient continues to be detained under the Act, for the following reasons— [Reasons should indicate why informal admission is not appropriate.]

……
……
……

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

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

The authority for the detention of the patient is/is not* due to expire within a period of two months beginning with the date on which this report is to be furnished to the hospital managers. <*Delete the phrase which does not apply*>

Complete the following only if the authority for detention is due to expire within that period of two months.

This report shall/shall not* have effect as a report duly furnished under section 20(3) for the renewal of the authority for the detention of the patient. <*Delete the phrase which does not apply*>

Complete the following in all cases.

I am furnishing this report by: <*Delete the phrase which does not apply*>

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed……
PRINT NAME……
Date……

PART 2

(To be completed on behalf of the hospital managers)

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system

received by me on behalf of the hospital managers on [date]

Signed……
on behalf of the hospital managers
PRINT NAME……
Date……

Form G1Mental Health Act 1983 section 7—guardianship application by nearest relative

Regulation 5(1)(a)(i) and (1)(b)

PART 1
(To be completed by the nearest relative)

To the [name of local social services authority]

I [PRINT your full name and address] apply for the reception of [PRINT full name and address of patient] into the guardianship of [PRINT full name and address of proposed guardian] in accordance with Part 2 of the Mental Health Act 1983.

Complete (a) or (b) as applicable and delete the other.

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Act.

I am the patient's [state your relationship with the patient].

(b) I have been authorised to exercise the functions under the Act of the patient's nearest relative by a county court/the patient's nearest relative <*delete the phrase which does not apply*>, and a copy of the authority is attached to this application.

*The patient's date of birth is [date]

OR

*I believe the patient is aged 16 years or over.
<**Delete the phrase which does not apply.*>

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

……
……
……

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

Signed……
Date……..

PART 2*

<*Complete only if proposed guardian is not a local social services authority>
(To be completed by the proposed guardian)

My full name and address is as entered in Part 1 of this form and I am willing to act as the guardian of the above named patient in accordance with Part 2 of the Mental Health Act 1983.

Signed……..
Date……..

Form G2Mental Health Act 1983 section 7—guardianship application by an approved mental health professional

Regulation 5(1)(a)(ii) and 5(1)(b)

PART 1

(To be completed by the approved mental health professional)

To the [name of local social services authority]

I [PRINT your full name and address] apply for the reception of [PRINT full name and address of patient] into the guardianship of [PRINT full name and address of proposed guardian] in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different.]

Complete the following where consultation with the nearest relative has taken place.

Complete (a) or (b) as applicable and delete the other.

(a) I have consulted [PRINT full name and address] who to the best of my knowledge and belief is the patient's nearest relative within the meaning of the Act;

(b) I have consulted [PRINT full name and address] who I understand has been authorised by a county court/ the patient's nearest relative to exercise the functions under the Act of the patient's nearest relative. *<Delete the phrase which does not apply>*

That person has not notified me or the local social services authority on whose behalf I am acting that he or she objects to this application being made.

Complete the following where the nearest relative has not been consulted.

Delete whichever two of (a), (b) and (c) do not apply.

(a) I have been unable to ascertain who is this patient's nearest relative within the meaning of the Act,

OR

(b) to the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act,

OR

(c) [PRINT full name and address] is

(i) this patient's nearest relative within the meaning of the Act,
(ii) authorised to exercise the functions of this patient's nearest relative under the Act,

<Delete either (i) or (ii)>

but in my opinion it is not reasonably practicable/would involve unreasonable delay *<delete as appropriate>* to consult that person before making this application, because—

……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

The remainder of Part 1 of this form must be completed in all cases.

I last saw the patient on [date], which was within the period of 14 days ending on the day this application is completed.

*The patient's date of birth is [date]

OR

*I believe the patient is aged 16 years or over.
*<*Delete the phrase which does not apply.>*

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient—

……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

Signed……
Date……

PART 2*

<*Complete only if proposed guardian is not a local social services authority>

(To be completed by the proposed guardian)

My full name and address is as entered in Part 1 of this form and I am willing to act as the guardian of the above named patient in accordance with Part 2 of the Mental Health Act 1983.

Signed……
Date……

Form G3Mental Health Act 1983 section 7— joint medical recommendation for reception into guardianship

Regulation 5(1)(c)(i)

We, registered medical practitioners, recommend that [PRINT full name and address of patient] be received into guardianship in accordance with Part 2 of the Mental Health Act 1983.

I [PRINT full name and address of first practitioner] last examined this patient on [date], and <**delete if not applicable*>

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

I [PRINT full name and address of second practitioner] last examined this patient on [date], and <**delete if not applicable*>

* I had previous acquaintance with the patient before I conducted that examination.

* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

In our opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act,

AND

(b) it is necessary
  (i) in the interests of the welfare of the patient
  (ii) for the protection of other persons
  <*delete (i) or (ii) unless both apply*>

that the patient should be so received.

Our reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient cannot appropriately be cared for without powers of guardianship.]

……
……
……

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

Signed……
Date……

Signed……
Date……

NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.

Form G4Mental Health Act 1983 section 7 —medical recommendation for reception into guardianship

Regulation 5(1)(c)(ii)

I [PRINT full name and address of practitioner], a registered medical practitioner recommend that [PRINT full name and address of patient] be received into guardianship in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date].

*I had previous acquaintance with the patient before I conducted that examination.

*I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder. <**Delete if not applicable*>

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act,

AND

(b) it is necessary
(i) in the interests of the welfare of the patient
(ii) for the protection of other persons
<*delete (i) or (ii) unless both apply*>

that the patient should be so received.

My reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient cannot appropriately be cared for without powers of guardianship.]

……
……
……

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

Signed……
Date……

Form G5Mental Health Act 1983 section 7 — record of acceptance of guardianship application

Regulation 5(2)

(To be attached to the guardianship application)

[PRINT full name and address of patient]

This application was accepted by/on behalf* of the local social services authority on [date].
<*Delete the phrase that does not apply>

Signed……
on behalf of the responsible local social services authority
PRINT NAME……
Date……

Form G6Mental Health Act 1983 section 19— authority for transfer from hospital to guardianship

Regulation 7(4)(a),(d) and (e)

PART 1

(To be completed on behalf of the managers of the hospital where the patient is detained)

Authority is given for the transfer of [PRINT full name of patient] who is at present liable to be detained in [name and address of hospital] to the guardianship of [PRINT full name and address of proposed guardian] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

This transfer was agreed by the [name of local social services authority] on [date of confirmation].

The transfer is to take place on [date].

Signed……
on behalf of the hospital managers
PRINT NAME……
Date……

PART 2*

<*Complete only if proposed guardian is not a local social services authority>

(To be completed by the proposed private guardian)

My full name and address is as entered in Part 1 of this form and I am willing to act as the guardian of the above named patient in accordance with Part 2 of the Mental Health Act 1983.

Signed……
Date……

IF THE GUARDIAN IS TO BE A PRIVATE GUARDIAN, THE TRANSFER MAY NOT TAKE PLACE UNTIL BOTH PARTS OF THIS FORM ARE COMPLETED

Form G7Mental Health Act 1983 section 19— authority for transfer of a patient from the guardianship of one guardian to another

Regulation 8(1)(a), (d)and (e)

PART 1

(To be completed by the present guardian)

Authority is given for the transfer of [PRINT full name and address of patient] from the guardianship of [PRINT full name and address of the present guardian] to the guardianship of [PRINT full name and address of the proposed guardian] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

This transfer was agreed by the [name of local social services authority] on [date of confirmation].

The transfer is to take place on [date].

Signed.....
the guardian/on behalf of the local social services authority which is the guardian
<*Delete whichever does not apply*>
PRINT NAME.....
Date.....

PART 2*
<*Complete only if proposed guardian is not a local social services authority>

(To be completed by the proposed private guardian)

My full name and address is as entered in Part 1 of this form and I am willing to act as the guardian of the above named patient in accordance with Part 2 of the Mental Health Act 1983.

Signed.....
Date.....

IF THE NEW GUARDIAN IS TO BE A PRIVATE GUARDIAN, THE TRANSFER MAY NOT TAKE PLACE UNTIL BOTH PARTS OF THIS FORM ARE COMPLETED

Form G8Mental Health Act 1983 section 19— authority for transfer from guardianship to hospital

Regulation 8(2) and (4)

PART 1

(To be completed on behalf of the local social services authority)

Authority is given for the transfer of [PRINT full name and address of patient] who is at present under the guardianship of [name and address of guardian] to [name and address of hospital] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

Signed……
on behalf of the local social services authority
PRINT NAME……
Date……

PART 2
RECORD OF ADMISSION

(This is not part of the authority for transfer but is to be completed at the hospital to which the patient is transferred)

This patient was admitted to the above named hospital in pursuance of this authority for transfer on [date of admission to receiving hospital] at [time].

Signed……
on behalf of the managers of the receiving hospital
PRINT NAME……
Date……

Form G9Mental Health Act 1983 section 20 — renewal of authority for guardianship

Regulation 13(4) and (5)

PART 1

(To be completed by the responsible clinician or nominated medical attendant)

To [name of guardian]
[name of responsible local social services authority if it is not the guardian]

I examined [PRINT full name and address of patient] on [date].

The patient is subject to guardianship for a period ending on [date authority for guardianship is due to expire].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act,

AND

(b) it is necessary
(i) in the interests of the welfare of the patient
(ii) for the protection of other persons
<*delete (i) or (ii) unless both apply*>

that the patient should remain under guardianship under the Act.

My reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient cannot appropriately be cared for without powers of guardianship.]

……
……
……

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

Signed……..
*Responsible clinician
*Nominated medical attendant
<* *Delete whichever does not apply.*>
PRINT NAME ……
Date ……

PART 2

(To be completed on behalf of the responsible local social services authority)

This report was received by me on behalf of the local social services authority on [date].

Signed……
on behalf of the local social services authority
PRINT NAME……
Date……

Form G10Mental Health Act 1983 section 21B — authority for guardianship after absence without leave for more than 28 days

Regulation 14(2)(a) and (b)

PART 1

(To be completed by the responsible clinician or nominated medical attendant)

To [name of guardian]
[name of responsible local social services authority if it is not the guardian]

I examined [PRINT full name and address of patient] on [date of examination] who:

(a) was absent without leave from the place where the patient is required to reside beginning on [date absence without leave began];
(b) was/is* subject to guardianship for a period ending on [date authority for guardianship would have expired, apart from any extension under section 21, or date on which it will expire]; <*d*elete phrase which does not apply*>* and
(c) returned to that place on [date].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act,

AND

(b) it is necessary
(i) in the interests of the welfare of the patient
(ii) for the protection of other persons
<delete (i) or (ii) unless both apply>

that the patient should remain under guardianship under the Act.

My reasons for these opinions are:

[Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient cannot appropriately be cared for without powers of guardianship.]

.....
.....
.....

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

The authority for the guardianship of the patient is/is not* due to expire within a period of two months beginning with the date on which this report is to be furnished. <*Delete the phrase which does not apply>

Complete the following only if the authority for guardianship is due to expire within that period of two months.

This report shall/shall not* have effect as a report duly furnished under section 20(6) for the renewal of the authority for the guardianship of the patient. <*Delete the phrase which does not apply>

Signed……..
*Responsible clinician
*Nominated medical attendant
<* Delete whichever does not apply>
PRINT NAME ……
Date ……

PART 2

(To be completed on behalf of the responsible local social services authority)

This report was received by me on behalf of the local social services authority on [date].

Signed……..……..
on behalf of the local social services authority
PRINT NAME……..
Date……

Form M1Mental Health Act 1983 Part 6—date of reception of a patient in England

Regulation 15(2), (4)(a) and 16(2)

[PRINT full name of patient]

*was admitted to [name and address of hospital] at [time] on [date]

*was received into the guardianship of [name and address of guardian] on [date]

*became a community patient as if discharged from [name and address of responsible hospital], on [date].
<*Complete as appropriate and delete the others>

Signed……
on behalf of the hospital managers/
on behalf of the local social services authority/
the private guardian
<Delete whichever do not apply>
PRINT NAME……
Date…… ……

Form M2Mental Health Act 1983 section 25—report barring discharge by nearest relative

Regulation 25(1)(a) and (b)

PART 1

(To be completed by the responsible clinician)

To the managers of [name and address of hospital]

[Name of nearest relative] gave notice at [time] on [date] of an intention to discharge [PRINT full name of patient].

I am of the opinion that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself or herself.

The reasons for my opinion are—

……
……
……

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

I am furnishing this report by: <*Delete the phrase which does not apply*>

consigning it to the hospital managers' internal mail system today at [time].

sending or delivering it without using the hospital managers' internal mail system.

Signed……
Responsible clinician
PRINT NAME……
Date…… ……
Time……

PART 2

(To be completed on behalf of the hospital managers)

This report was: <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers at [time] on [date].

Signed……
on behalf of the hospital managers
PRINT NAME……
Date…… ……

Form T1Mental Health Act 1983 section 57—certificate of consent to treatment and second opinion

Regulation 27(1)(b)

(Both parts of this certificate must be completed)

PART 1

I [PRINT full name and address], a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD), and we [PRINT full name, address and profession], being two persons appointed for the purposes of section 57(2)(a) of the Act, certify that [PRINT full name and address of patient]

(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……

Signed……
Date……

Signed……
Date……

PART 2

(To be completed by SOAD only)

I, the above named registered medical practitioner appointed for the purposes of Part 4 of the Act have consulted [PRINT full name of nurse] a nurse and [PRINT full name and profession] who have been professionally concerned with the medical treatment of the patient named above and certify that it is appropriate for the 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……

Form T2Mental Health Act 1983 section 58(3)(a)—certificate of consent to treatment

Regulation 27(2)

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 the phrase which does not apply*> certify that [PRINT full name and address of patient]

(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.....

Form T3Mental Health Act 1983 section 58(3)(b)—certificate of second opinion

Regulation 27(2)

I [PRINT full name and address], a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD), have consulted [PRINT full name of nurse], a nurse and [PRINT full name and profession] who have been professionally concerned with the medical treatment of [PRINT full name and address of patient].

I certify that the patient— <*Delete the phrase which does not apply*>

(a) is not capable of understanding the nature, purpose and likely effects of

(b) has not consented to

the following treatment: [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]

but that it is appropriate for the 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.....

Form T4Mental Health Act 1983 section 58A(3)—certificate of consent to treatment (patients at least 18 years old)

Regulation 27(3)(b)

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.....

Form T5Mental Health Act 1983 section 58A(4)—certificate of consent to treatment and second opinion (patients under 18)

Regulation 27(3)(b)

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

I [PRINT full name and 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.

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.....

Form T6Mental Health Act 1983 section 58A(5)—certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment)

Regulation 27(3)(b)

I [PRINT full name and address], a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD), have consulted [PRINT full name of nurse] a nurse and [PRINT full name and profession] who have been professionally concerned with the medical treatment of [PRINT full name and address of patient].

I certify that the patient is not 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]

but that it is appropriate for the 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.]

I further certify that giving the treatment described above to the patient would not conflict with—

(i) any decision of an attorney appointed under a Lasting Power of Attorney or deputy (appointed by the Court of Protection) of the patient as provided for by the Mental Capacity Act 2005

(ii) any decision of the Court of Protection, or

(iii) any advance decision to refuse treatment that is valid and applicable under the Mental Capacity Act 2005.

Signed.....

Date.....

Form CTO1Mental Health Act 1983 section 17A—community treatment order

Regulation 6(1)(a), (b) and 6(2)(a)

(Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional)

PART 1

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of patient].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment,

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<delete any phrase which is not applicable>

that the patient should receive such treatment;

(c) such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment;

(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

My opinion is founded on the following grounds—

.....

.....

.....

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

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were not detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Conditions to which the patient is to be subject by virtue of this community treatment order

The patient is to make himself or herself available for examination under section 20A, as requested.

If it is proposed to give a certificate under Part 4A of the Act in the patient's case, the patient is to make himself or herself available for examination to enable the certificate to be given, as requested.

The patient is also to be subject to the following conditions (if any) under section 17B(2) of the Act:
……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I confirm that I consider the above conditions to be made under section 17B(2) of the Act are necessary or appropriate for one or more of the following purposes:

- to ensure that the patient receives medical treatment
- to prevent risk of harm to the patient's health or safety
- to protect other persons.

Signed……
Date……..……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by <*delete as appropriate*>

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the above patient meets the criteria for a community treatment order to be made

(ii) it is appropriate to make a community treatment order, and

(iii) the conditions made above under section 17B(2) are necessary or appropriate for one or more of the purposes specified.

Signed:……
Approved mental health professional
Date:……

PART 3

I exercise my power under section 17A of the Mental Health Act 1983 to make a community treatment order in respect of the patient named in Part 1 of this Form.

This community treatment order is to be effective from [date] at [time].

Signed:……
Responsible clinician
Date:……

THIS COMMUNITY TREATMENT ORDER IS NOT VALID UNLESS ALL THREE PARTS ARE COMPLETED AND SIGNED

IT MUST BE FURNISHED AS SOON AS PRACTICABLE TO THE MANAGERS OF THE HOSPITAL IN WHICH THE PATIENT WAS LIABLE TO BE DETAINED BEFORE THE ORDER WAS MADE

Form CTO2Mental Health Act 1983 section 17B—variation of conditions of a community treatment order

Regulation 6(2)(b)

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of the community patient].

I am varying the conditions attaching to the community treatment order for the above named patient.

The conditions made under section 17B(2), as varied, are: [List the conditions as varied in full (including any which are not being varied) or state that there are no longer to be any such conditions.]

.....
.....
.....

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

The variation is to take effect from [date].

I confirm that I consider the above conditions to be necessary or appropriate for one or more of the following purposes:

- to ensure that the patient receives medical treatment
- to prevent risk of harm to the patient's health or safety
- to protect other persons.

Signed.....
Responsible clinician
Date..... .....

THIS FORM MUST BE FURNISHED AS SOON AS PRACTICABLE TO THE MANAGERS OF THE RESPONSIBLE HOSPITAL

Form CTO3Mental Health Act 1983 section 17E—community treatment order: notice of recall to hospital

Regulation 6(3)(a)

(To be completed by the responsible clinician)

I notify you, [PRINT name of community patient], that you are recalled to [PRINT full name and address of the hospital] under section 17E of the Mental Health Act 1983.

Complete either (a) or (b) below and delete the one which does not apply.

(a) In my opinion,

(i) you require treatment in hospital for mental disorder,

AND

(ii) there would be a risk of harm to your health or safety or to other persons if you were not recalled to hospital for that purpose.

This opinion is founded on the following grounds—

.....

.....

.....

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

(b) You have failed to comply with the condition imposed under section 17B of the Mental Health Act 1983 that you make yourself available for examination for the purpose of: *<delete as appropriate>*

(i) consideration of extension of the community treatment period under section 20A

(ii) enabling a Part 4A certificate to be given.

Signed.....
Responsible clinician
PRINT NAME.....
Date.....
Time.....

A COPY OF THIS NOTICE IS TO BE FORWARDED TO THE MANAGERS OF THE HOSPITAL TO WHICH THE PATIENT IS RECALLED AS SOON AS POSSIBLE AFTER IT IS SERVED ON THE PATIENT. IF THAT HOSPITAL IS NOT THE RESPONSIBLE HOSPITAL, YOU SHOULD INFORM THE HOSPITAL MANAGERS THE NAME AND ADDRESS OF THE RESPONSIBLE HOSPITAL.

This notice is sufficient authority for the managers of the named hospital to detain the patient there in accordance with the provisions of section 17E of the Mental Health Act 1983.

Form CTO4Mental Health Act 1983 section 17E — community treatment order: record of patient's detention in hospital after recall

Regulation 6(3)(d)

[PRINT full name and address of patient] ('the patient') is currently a community patient.

In pursuance of a notice recalling the patient to hospital under section 17E of the Act, the patient was detained in [full name and address of hospital] on [enter date and time at which the patient's detention in the hospital as a result of the recall notice began].

Signed.....
on behalf of the hospital managers
PRINT NAME.....
Date.....
Time.....

Form CTO5Mental Health Act 1983 section 17F(4)—revocation of community treatment order

Regulation 6(8)(a) and (b)

(Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional)

PART 1

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of community patient] who is detained in [name and address of hospital] having been recalled to hospital under section 17E(1) of the Act.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary for
(i) the patient's own health
(ii) the patient's own safety
(iii) the protection of other persons
<*delete the indents not applicable*>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained for medical treatment under the Act,

because— [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]

……
……
……

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

I am also of the opinion that taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient at the hospital named above.

Signed……
Responsible clinician

Date…… ……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the patient meets the criteria for detention in hospital set out above and

(ii) it is appropriate to revoke the community treatment order.

Signed.....
Approved mental health professional
Date.....

PART 3

I exercise my power under section 17F(4) to revoke the community treatment order in respect of the patient named in Part 1 who has been detained in hospital since [time] on [date], having been recalled under section 17E(1).

Signed.....
Responsible clinician
Date..... .....

THIS REVOCATION ORDER IS NOT VALID UNLESS ALL THREE PARTS ARE COMPLETED AND SIGNED

IT MUST BE SENT AS SOON AS PRACTICABLE TO THE MANAGERS OF THE HOSPITAL IN WHICH THE PATIENT IS DETAINED

Form CTO6Mental Health Act 1983 section 17F(2)—authority for transfer of recalled community patient to a hospital under different managers

Regulation 9(3)(a) and (5)

(To be completed on behalf of the managers of the hospital in which the patient is detained by virtue of recall)

PART 1

This form authorises the transfer of [PRINT full name of patient] from [name and address of hospital in which the patient is detained] to [name and address of hospital to which patient is to be transferred] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

I attach a copy of Form CTO4 recording the patient's detention in hospital after recall.

*The hospital in which the patient is currently detained is the patient's responsible hospital.

*The hospital to which the patient is to be transferred is the patient's responsible hospital.

*The patient's responsible hospital is [name and address of responsible hospital].
<*Delete the phrases which do not apply>

Signed……
on behalf of managers of the first named hospital

PRINT NAME……
Date…… ……

PART 2

RECORD OF ADMISSION

(This is not part of the authority for transfer but is to be completed at the hospital to which the patient is transferred)

This patient was admitted to [name of hospital] in pursuance of this authority for transfer on [date of admission to receiving hospital] at [time].

Signed……
on behalf of managers of the receiving hospital
PRINT NAME……
Date…… ……

Form CTO7Mental Health Act 1983 section 20A — community treatment order: report extending the community treatment period

Regulation 13(6)(a) and (b), and 13(7)

Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional. Part 4 is to be completed by or on behalf of the managers of the responsible hospital.

PART 1

To the managers of [name and address of the responsible hospital]

I am [PRINT full name and address of the responsible clinician] the responsible clinician for [PRINT full name and address of patient].

The patient is currently subject to a community treatment order made on [enter date].

I examined the patient on [date].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<delete any indent which is not applicable>

that the patient should receive such treatment;

(c) such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

My opinion is founded on the following grounds—

……

……

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

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were to continue not to be detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Signed……
Responsible clinician

Date…… ……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the patient meets the criteria for the extension of the community treatment period and

(ii) it is appropriate to extend the community treatment period.

Signed……
Approved mental health professional

Date……

PART 3

Before furnishing this report, I consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

I am furnishing this report by: *<Delete the phrase which does not apply>*

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed……
Responsible clinician

Date……

THIS REPORT IS NOT VALID UNLESS PARTS 1, 2 & 3 ARE COMPLETED AND SIGNED

PART 4

This report was *<Delete the phrase which does not apply>*

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers on [date].

Signed……..
on behalf of the managers of the responsible hospital

PRINT NAME……

Date…… ……

Form CTO8Mental Health Act 1983 section 21B—authority for extension of community treatment period after absence without leave for more than 28 days

Regulation 14(3)(a) and (b)

PART 1

(To be completed by the responsible clinician)

To the managers of [enter name and address of responsible hospital]

I am [PRINT full name and address of the responsible clinician] the responsible clinician for [PRINT full name and address of patient].

I examined the patient on [date of examination] who:

(a) was recalled to hospital on [date] under section 17E of the Mental Health Act 1983;

(b) was absent without leave from hospital beginning on [date absence without leave began];

(c) was/is <*delete as appropriate*> subject to a community treatment order for a period ending on [date community treatment order would have expired, apart from any extension under section 21, or date on which it will expire]; and

(d) returned to the hospital on [date].

I have consulted [PRINT full name of approved mental health professional] who is an approved mental health professional.

I have also consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<*delete any indent which is not applicable*>

that the patient should receive such treatment;

(c) such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were to continue not to be detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

My opinion is founded on the following grounds—

……

……

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

The community treatment order is/is not* due to expire within a period of two months beginning with the date on which this report is to be furnished to the managers of the responsible hospital. <**Delete the phrase which does not apply*>

Complete the following only if the authority for detention is due to expire within that period of two months.

This report shall/shall not* have effect as a report duly furnished under section 20A(4) for the extension of the community treatment period for this patient. <**Delete the phrase which does not apply*>

Complete the following in all cases.

I am furnishing this report by: <*Delete the phrase which does not apply*>

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed……
Date……

PART 2

(To be completed on behalf of the managers of the responsible hospital)

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers on [date].

Signed……
on behalf of the hospital managers
PRINT NAME……
Date……

Form CTO9Mental Health Act 1983 Part 6—community patients transferred to England

Regulation 16(4) and (5)

PART 1

(To be completed by the responsible clinician)

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of patient] who is treated as if subject to a community treatment order having been transferred to England.

The patient is to be subject to the following conditions by virtue of that community treatment order:

The patient is to make himself or herself available for examination under section 20A, as requested.

If it is proposed to give a certificate under Part 4A of the Act in the patient's case, the patient is to make himself or herself available for examination to enable the certificate to be given, as requested.

The patient is also to be subject to the following conditions (if any) under section 17B(2) of the Act:

……

……

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

I confirm that I consider the above conditions to be made under section 17B(2) of the Act are necessary or appropriate for one or more of the following purposes:

- to ensure that the patient receives medical treatment
- to prevent risk of harm to the patient's health or safety
- to protect other persons.

Signed……
Responsible clinician
Date……

PART 2

(To be completed by the approved mental health professional)

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<Delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that the conditions made above under section 17B(2) are necessary or appropriate for one or more of the purposes specified.

Signed……
Approved mental health professional
Date……

THE PATIENT IS NOT SUBJECT TO THE CONDITIONS SET OUT IN THIS FORM UNLESS BOTH PARTS OF THE FORM ARE COMPLETED.

Form CTO10Mental Health Act 1983 section 19A—authority for assignment of responsibility for community patient to hospital under different managers

Regulation 17(3)(a) and (d)(i) and (ii)

(To be completed on behalf of the responsible hospital)

This form gives authority for the assignment of responsibility for [PRINT full name and address of patient] from [name and address of responsible hospital] to [name and address of hospital to which responsibility is to be assigned in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

This assignment was agreed by the managers of the hospital to which the responsibility is to be assigned on [date of confirmation]

The assignment is to take place on [date].

Signed.....
on behalf of managers of first named hospital
PRINT NAME.....
Date..... .....

Form CTO11Mental Health Act 1983 section 64C(4) — certificate of appropriateness of treatment to be given to community patient (Part 4A certificate)

Regulation 28(1)

(To be completed on behalf of the responsible hospital)

I [PRINT full name and address] am a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD).

I have consulted [PRINT full name and profession] and [full name and profession] who have been professionally concerned with the medical treatment of [PRINT full name and address of patient] who is subject to a community treatment order.

I certify that it is appropriate for the following treatment to be given to this patient while the patient is not recalled to hospital, subject to any conditions specified below. The treatment is: [Give description of treatment or plan of treatment.]

……
……
……

I specify the following conditions (if any) to apply: [Conditions may include time-limits on the approval of any or all of the treatment.]

……..
……..
……..

I certify that it is appropriate for the following treatment (if any) to be given to this patient following any recall to hospital under section 17E of the Act, subject to any conditions specified below. The treatment is: [Give description of treatment or plan of treatment].

……...
……
……

I specify the following conditions (if any) to apply to the treatment which may be given to the patient following any recall to hospital under section 17E: [Conditions may include time-limits on the approval of any or all of the treatment.]

……...
……...
……

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 for any of the above please indicate here [ ] and attach that sheet to this form.]

Signed ……
Date……..……