MHA11A

Mental Health Act 1986

Sections 15A

Local Hospital Patient Number: | | | | | | | | | | |

Family Name: _____

Given Names: _____

Date of Birth: _____ **Sex:** _____

Mental Health Statewide Patient Number | | | | | | | | |

Alias: _____

RESTRICTED COMMUNITY TREATMENT ORDER

Notes to completing this form

The decision to make a restricted community treatment order (RCTO) must be consistent with the treatment objectives and strategies contained in the patient's treatment plan.

The patient must be given a copy of this *Restricted Community Treatment Order* and:

- told the RCTO has been made.
- told the grounds for the decision to make a RCTO.

A treatment plan should be prepared to accompany this *Restricted Community Treatment Order.*

_____
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of patient

a patient of: _____
approved mental health service

residing at: _____
address of patient living in the community

TO THE PATIENT

(1) Having examined you, I am satisfied that **all** the following criteria in section 93(1)(a) of the **Sentencing Act 1991** apply to you:
   (a) you appear to be mentally ill; and
   (b) your mental illness requires treatment and that treatment can be obtained by you being subject to a restricted involuntary treatment order; and
   (c) because of your mental illness, involuntary treatment is necessary for your health or safety (whether to prevent a deterioration in your physical or mental condition or otherwise) or for the protection of members of the public.

(2) I am satisfied that the treatment you require can be obtained through the making of a restricted community treatment order.

(3) I therefore make a restricted community treatment order for you.

(4) This order will remain in force until it is either revoked, discharged or your restricted involuntary treatment order expires.

(5) The conditions of your restricted community treatment order are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I am the *delegated / authorised psychiatrist of the approved mental health service / chief psychiatrist.

☐ The patient has been given a copy of the patients' rights booklet *Restricted Involuntary Treatment Orders* and the information explained.

☐ A treatment plan has been prepared and discussed with the patient.

(please cross ☒)

_____
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of *delegated/ authorised psychiatrist/chief psychiatrist

Signed: _____ Date: | | | | | | | | |

* delete as necessary

Original - ADMIN. Make copies for PATIENT FILE, PATIENT, MONITORING PSYCHIATRIST, CHIEF PSYCHIATRIST and SUPERVISING MEDICAL PRACTITIONER

ROLLS FILING SYSTEMS (03) 8770 1111

OCT 2006

MHA 11A RESTRICTED COMMUNITY TREATMENT ORDER