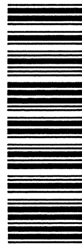

MHA13A

Mental Health Act 1986

Section 15C

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

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

Family Name: ____________________

Given Names: ____________________

Date of Birth: ____________ **Sex:** ________

Alias: ____________________

VARIATION OF RESTRICTED COMMUNITY TREATMENT ORDER

Notes to completing this form

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

Reasons to vary a RCTO
A RCTO may be varied to:

- Add or remove a condition.
- Change the responsible approved mental health service- for example, following a transfer.

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

- told the RCTO has been varied.
- told the grounds for the decision to vary the RCTO.

____
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) 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 continue to be obtained through a restricted community treatment order.

(3) I consider that it is necessary to vary your restricted community treatment order.

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

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

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

☐ The patient's treatment plan has been reviewed, revised 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

MHA 13A VARIATION OF RESTRICTED COMMUNITY TREATMENT ORDER

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OCT 2006