Mental Health Act 1986

Section 39

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

Family Name: _____

Given Names: _____

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

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

Alias: _____

TRANSFER OF AN INVOLUNTARY PATIENT TO ANOTHER APPROVED MENTAL HEALTH SERVICE

Notes to completing this form

The patient must be given a copy of this *Transfer of an Involuntary Patient to Another Approved Mental Health Service.*

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

☐ an involuntary patient subject to:
- ☐ an **involuntary treatment order.**
- ☐ a **community treatment order.**
- ☐ a **restricted involuntary treatment order** under section 93 Sentencing Act 1991**.**
- ☐ a **restricted community treatment order.**
- ☐ a **diagnosis, assessment & treatment order** under section 91 Sentencing Act 1991.
- ☐ an **assessment order** under section 90 Sentencing Act 1991.
- ☐ continued detention and treatment under section 12A or 12C.

(please cross ☒ relevant options)

a patient of: _____
unit / team at the approved mental health service (includes gazetted emergency departments)

at: _____
approved mental health service

TO THE PATIENT

(1) I order that you be transferred on the _____ day of _____ 20_____
to: _____
unit / team at the receiving approved mental health service

_____
receiving approved mental health service

(2) The reasons for my decision are: _____

(3) I am satisfied that the transfer:
- ☐ will be of benefit to you.
- ☐ is necessary for your treatment.

(please cross ☒ whichever applies)

(4) You may appeal to the Mental Health Review Board against the transfer. Ask your case manager or a member of the treating team if you need help to make an appeal.

Any documents relevant to the admission and future treatment of the patient must be forwarded at the same time to the receiving approved mental health service.

I am the * delegated / authorised psychiatrist of the approved mental health service.
(please cross ☒)

☐ I have discussed the proposed transfer with the patient.

☐ I consulted the following *delegated / authorised psychiatrist of the receiving approved mental health service and he/she approves of the transfer:

Name: _____ Date: | | | | | | |
name of delegated/authorised psychiatrist consulted date consulted

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

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

* delete as necessary

MHA 19 TRANSFER TO ANOTHER AMHS

ROLLS FILING SYSTEMS (03) 8770 1111

OCT 2008