Mental Health Act 1986

Sections 40 & 41

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

Family Name: _____

Given Names: _____

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

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

Alias: _____

LEAVE OF ABSENCE FOR AN INVOLUNTARY PATIENT

Notes to completing this form

This form is for use whenever an involuntary patient is to be absent overnight or longer periods, and at other times at the discretion of the delegated / authorised psychiatrist.

The patient must be given a copy of this *Leave of Absence for an Involuntary Patient.*

_____

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

☐ an involuntary patient subject to:

- ☐ an **involuntary treatment order.**
- ☐ a **restricted involuntary treatment order** under section 93 Sentencing Act 1991.
- ☐ 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: _____

approved mental health service

TO THE PATIENT

(1) I allow you:

(please cross ☒ one option only)

☐ leave of absence from: | | | | | | | to: | | | | | | |

for the purpose of: _____

OR

☐ medical treatment leave from: | | | | | | | to: | | | | | | |

at: _____

name of treating health service

_____

address of treating health service

The conditions of the leave must specify actions to take in a crisis, including 24-hour contact telephone numbers.

(2) The conditions of your leave are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The decision to grant leave of absence must be made within the context of the treatment objectives and strategies contained in the patient's treatment plan.

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

☐ I have discussed the leave of absence and the conditions with the patient.

(please cross ☒)

_____

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

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

* delete as necessary

White - ADMIN Yellow - PATIENT FILE Green - PATIENT

MHA 21 LEAVE - INVOLUNTARY PATIENT

ROLLS FILING SYSTEMS (03) 8770 1111

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