MHA3

Mental Health Act 1986

Sections 12AD, 12AE, 16(B) & 17A

Local Hospital Patient Number:

Family Name: _____

Given Names: _____

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

Mental Health Statewide Patient Number

Alias: _____

EXAMINATION OF SECURITY/INVOLUNTARY/ FORENSIC PATIENT BY AUTHORISED PSYCHIATRIST

Notes to completing this form

The delegated/ authorised psychiatrist should examine the patient within 24 hours after the order is made.

For involuntary and security patients, the delegated/authorised psychiatrist should be satisfied that the relevant legislative criteria apply to the patient. If they do not, the psychiatrist must notify the chief psychiatrist without delay. Complete either the *Discharge from Restricted Involuntary Treatment Order/ Assessment Order/ Diagnosis, Assessment and Treatment Order* (MHA 17A) form or the *Discharge of Security/ Involuntary Patient* (MHA 18) form.

When a restricted involuntary treatment order (RITO) is made, the delegated/ authorised psychiatrist must either:

- admit the person as an involuntary inpatient (a RITO is sufficient authority to detain the person in the approved mental health service).

or

- make a restricted community treatment order without admitting the patient to the service.

A copy of any guardianship order must be placed in the patient's clinical record.

_____

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

☐ a security patient subject to:
- ☐ a **restricted hospital transfer order** under section 16(3)(b).
- ☐ a **hospital security order** under section 93A Sentencing Act 1991.

☐ an involuntary patient subject to:
- ☐ 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.
- ☐ a **hospital transfer order** under section 16(3)(a).

☐ a forensic patient under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

(please cross ☒ relevant options)

a patient of: _____
approved mental health service

Complete sections (1) - (2) for security and involuntary patients only

(1) I am satisfied that the relevant legislative criteria for the Order apply to the patient.

(2) I base my opinion on the following facts observed on examination:

_____

_____

_____

_____

Complete section (3) for patients subject to restricted involuntary treatment orders

(3) I consider that the treatment required for the patient:

☐ can be obtained through making a restricted community treatment order. I will make a restricted community treatment order without delay.

OR

☐ cannot be obtained through making a restricted community treatment order. I therefore order that the patient be detained in the approved mental health service.

(please cross ☒ one option only)

Complete sections (4) - (5) for all security / involuntary / forensic patients

(4) I consider that the patient:

☐ is not capable of consenting to treatment for *his/her mental illness and I consent to psychiatric treatment on *his/her behalf.

OR

☐ is capable of consenting to treatment for *his/her mental illness but has refused to consent to necessary treatment and I consent to necessary psychiatric treatment on *his/her behalf.

OR

☐ is capable of consenting to treatment for *his/her mental illness and has consented to the necessary psychiatric treatment.

(please cross ☒ one option only)

(5) I have made inquiries and:

☐ determined that the patient has a guardian. The guardian *has been / will be as soon as is practicable notified of the admission and the grounds for it.

OR

☐ do not believe the patient has a guardian.

(please cross ☒ one option only)

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

☐ I have personally examined the abovenamed patient.

☐ The patient has been given a copy of the patients' right booklet **Restricted Involuntary Treatment Orders / Security Patients / Forensic Patients* and the information explained.

(please cross ☒)

_____

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

Signed: _____ Date: ☐☐/☐☐/☐☐ Time: ☐☐:☐☐ 24 hour

* delete as necessary

MHA 3 EXAMINATION OF SECURITY/INVOLUNTARY/ FORENSIC PATIENT BY AUTHORISED PSYCHIATRIST

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White - ADMIN Yellow - PATIENT FILE