



Mental Health Act 1986

Sections 47(4) & 106A

Local Hospital Patient Number: [] [] [] [] [] [] [] [] [] []

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: _____

Alias: _____

Mental Health Statewide Patient Number [] [] [] [] [] [] [] [] [] []

Mental Health Act 1986

Sections 47(4) & 106A

Local Hospital Patient Number: [] [] [] [] [] [] [] [] [] []

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: _____

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Mental Health Statewide Patient Number [] [] [] [] [] [] [] [] [] []

NOTICE OF DEATH OF PERSON UNDERGOING TREATMENT OR CARE FOR A MENTAL DISORDER

Notes to completing this form

The authorised psychiatrist of each approved mental health service and the person in charge of any other 'psychiatric service' within the meaning of section 106, must report to the chief psychiatrist the death of any person receiving treatment or care for a mental disorder which is a 'reportable death' within the meaning of the Coroners Act 1985.

If the deceased is a security patient, a copy of this notice must be sent to (as the case may be):

- Secretary to the Department of Justice; or
Secretary to the Department of Human Services; or
Chief Commissioner of Police.

Reporting

1. The death of an inpatient that is unexpected, violent or unnatural - the senior clinician on duty must, to the fullest extent possible, complete the first page of this Notice of Death and fax it to the chief psychiatrist on 9096 7697 within 24 hours.

2. The death of any patient that is unexpected, violent or unnatural - a fully completed Notice of Death and a full clinical summary must be sent to the chief psychiatrist within 2 weeks.

3. The death of any patient that is expected or the result of natural causes - a completed Notice of Death must be sent to the chief psychiatrist as soon as possible.

Further Information

For further information contact the chief psychiatrist on 1300 767 299.

TO THE CHIEF PSYCHIATRIST

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of deceased person

residing at: _____ last known address of deceased person

The person at the time of their death was:

- a person receiving treatment on a voluntary basis:
in an approved mental health service.
from any other psychiatric service within the meaning of section 106.
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.
a hospital transfer order under section 16(3)(a).
continued detention and treatment under section 12A or 12C.
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.
a forensic patient.
a person subject to a non-custodial supervision order.

(please cross [x])
a patient of: _____ approved mental health service / psychiatric service

Date of death: [] [] [] [] [] [] Time of death: [] [] [] [] 24 hour

Place of death: _____

Manner of death: _____

Death was unexpected, unnatural or violent: [] Yes [] No [] Unknown (If yes-see notes 1 & 2 opposite)

Inpatient death: [] Yes [] No If yes, specify date of admission: [] [] [] [] [] []

Date of last community contact: [] [] [] [] [] [] Date of last inpatient discharge: [] [] [] [] [] []

Coroner notified: [] Yes [] No Date coroner notified: [] [] [] [] [] []

Name of treating psychiatrist: _____

Name of case manager/primary nurse: _____

Primary psychiatric diagnosis (text and ICD code): _____

Secondary psychiatric diagnosis (text and ICD code): _____

Prescribed medication at time of death: _____

Form completed by:

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of person completing the form

Signed: _____ Designation: _____ Date: [] [] [] [] [] []

Please provide a clinical report about the person that includes (where relevant):

- A brief clinical history.
Details of the treatment and management of the person prior to their death.
Presentation / mental state on last contact.
Frequency of contacts & next scheduled appointment.
Identified risks and the measures taken to address any risks.
Known medical conditions.
Circumstances of the death (to the extent known).
Any other relevant information.

Further details may be attached if there is insufficient space.

TO THE CHIEF PSYCHIATRIST: Clinical Report

Blank lines for clinical report text.

Form completed by:

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of person completing the form

Signed: _____ Designation: _____ Date: [] [] [] [] [] []

Authorised by:

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of * delegated / authorised psychiatrist/ person in charge of service

Signed: _____ Date: [] [] [] [] [] []

* delete as necessary

Incomplete or insufficient reports will be returned for revision.