Mental Health Act 1986

Section 14

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

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

Family Name: ____________________

Given Names: ____________________

Date of Birth: ____________________ **Sex:** __________

Alias: ____________________

COMMUNITY TREATMENT ORDER

Notes to completing this form

The decision to make a community treatment order must be consistent with the treatment objectives and strategies contained in the patient's treatment plan.

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

- told the CTO has been made.
- told the grounds for the decision to make a CTO.

The duration of the community treatment order must not exceed 12 months.

A residence condition should only be included if it is necessary for the treatment of the person's mental illness.

A treatment plan should be prepared to accompany this *Community Treatment Order.*

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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) Having examined you, I am satisfied that all the following criteria in section 8(1) of the **Mental Health Act 1986** apply to you:

(a) you appear to be mentally ill *(a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory);* and

(b) your mental illness requires immediate treatment and that treatment can be obtained by you being subject to an 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; and

(d) you have refused or are unable to consent to the necessary treatment for the mental illness; and

(e) you cannot receive adequate treatment for the mental illness in a manner less restrictive of your freedom of decision and action.

(2) I am satisfied that the treatment you require can be obtained through the making of a community treatment order.

(3) I therefore make a community treatment order for you.

(4) The duration of your community treatment order is:

from: | | | | | | | until: | | | | | | |

ONLY COMPLETE THIS PART IF A RESIDENCE CONDITION IS TO BE ORDERED

5) You must live at: ____________________

address at which patient must live

because this is necessary for the treatment of your mental illness.

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

☐ The patient has been given a copy of the patients' rights booklet *Involuntary Patient* and the information explained.

☐ I have attached the patient's treatment plan and discussed it 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 6 CTO

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