

Mental Health Act 1986

Section 14C

Local Hospital Patient Number:

Grid for Local Hospital Patient Number

Family Name:

Given Names:

Date of Birth:

Sex:

Alias:

Mental Health Statewide Patient Number

Grid for Mental Health Statewide Patient Number

VARIATION OF COMMUNITY TREATMENT ORDER

Notes to completing this form

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

Reasons to vary a CTO

- A CTO may be varied to:
• Add or remove a residence condition.
• Change the responsible approved mental health service...
• Shorten the period of the order.

- The patient must be given a copy of this Variation of Community Treatment Order and:
• told the CTO has been varied.
• told the grounds for the decision to vary the CTO.

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

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of patient
a patient of: approved mental health service
residing at: address of patient

DETAILS OF COMMUNITY TREATMENT ORDER TO BE VARIED

Date made:

Grid for Date made

Date due to expire:

Grid for Date due to expire

TO THE PATIENT

- (1) 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...
(b) your mental illness requires immediate treatment...
(c) because of your mental illness, involuntary treatment is necessary...
(d) you have refused or are unable to consent...
(e) you cannot receive adequate treatment...
(2) I am satisfied that the treatment you require can continue to be obtained through a community treatment order.
(3) I consider that it is necessary to vary your community treatment order in the following manner and for the following reasons:

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

Grid for duration from

Grid for duration 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's treatment plan has been reviewed, revised and discussed with the patient. (please cross X)

GIVEN NAME/S

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

Signed:

Date:

Grid for Date

* delete as necessary



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