

Mental Health Act 1986

Section 14B

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

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: _____

Alias: _____

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

EXTENSION OF COMMUNITY TREATMENT ORDER

Notes to completing this form

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

A CTO cannot be extended after it has expired.

The patient must be given a copy of this Extension of Community Treatment Order and:
• told the CTO has been extended.
• told the grounds for the decision to extend the CTO.

The extension takes effect from the date this form is completed. The duration of the extended CTO must not exceed 12 months from the date this form is signed.

A residence condition should only be included if it 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 DUE TO EXPIRE

Date made: [] [] [] [] [] [] Date due to expire: [] [] [] [] [] []

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 continue to be obtained through a community treatment order.
(3) I therefore extend your community treatment order from the date this form is signed until: [] [] [] [] [] []
(4) The Mental Health Review Board will review this extension within the next 8 weeks

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.

[] I personally examined the abovenamed patient on: [] [] [] [] [] [] at: [] [] [] [] [] [] 24 Hour

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

[] 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: [] [] [] [] [] []

* delete as necessary

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