

**Mental Health and Wellbeing Act 2022
Sections 200 - 202**

**MHWA 111
Variation of Temporary Treatment
Order or Treatment Order**

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Mental Health Statewide UR Number

Local Patient Identifier

FAMILY NAME

GIVEN NAMES

DATE OF BIRTH

SEX

GENDER

Place patient identification label above

Instructions to complete this form

- This form must be completed by an Authorised Psychiatrist or Delegate to vary the setting of a Temporary Treatment Order or Treatment Order, from an inpatient order to a community order (or vice versa).
- You can only vary a community order to an inpatient order if you are satisfied that treatment of the person cannot occur in the community.
- A variation does not affect the duration of the Order.

GIVEN NAMES

FAMILY NAME (BLOCK LETTERS)

a patient of:

who is subject to:

Designated Mental Health Service

- a Temporary Treatment Order
- a Treatment Order.

(please cross one option only)

1. I am satisfied that the immediate treatment the person needs:

(please cross one option only)

- can** be provided in the community and vary the person's:
 - Inpatient Temporary Treatment Order to a Community Temporary Treatment Order
 - Inpatient Treatment Order to a Community Treatment Order

(please cross one option only)

OR

- cannot** be provided in the community and vary the person's:
 - Community Temporary Treatment Order to an Inpatient Temporary Treatment Order
 - Community Treatment Order to an Inpatient Treatment Order

(please cross one option only)

2. The reasons for my decision are:

3 I have given proper consideration to the decision-making principles for treatment and interventions

4. I have had regard:

- | | |
|--|--|
| <input type="checkbox"/> the views and preferences of the person and their reasons | <input type="checkbox"/> the views of a carer, if varying the Order will directly affect the carer and the care relationship |
| <input type="checkbox"/> the person's advance statement of preferences | <input type="checkbox"/> the views of the Secretary, Department of Families, Fairness and Housing if that Secretary has parental responsibility for the person under a relevant Child Protection Order |
| <input type="checkbox"/> the views expressed by the nominated support person | |
| <input type="checkbox"/> the views of a parent, if the person is under the age of 16 years | |
| <input type="checkbox"/> the views of any guardian of the person | |

(please indicate all persons consulted)

5. Date and time Temporary Treatment Order or Treatment Order is varied:

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date

--	--	--	--

at:

time 24 hour

Signature:

Date:

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signature of Authorised Psychiatrist or Delegate

Given Names:

Family Name:

Designation:

Variation of Temporary Treatment Order or Treatment Order MHWA 111



MHWA111

ROLLS AUSTRALIA 1300 600 192

**JULY
2023**

Original – medical record

Copy – patient