Mental Health and Wellbeing Act 2022
Sections 212 and 214

MHWA 120
Leave of absence for compulsory patient

Mental Health Statewide UR Number

Local Patient Identifier										
FAMILY NAME										
GIVEN NAMES										
DATE OF BIRTH	SEX	GENDER								

Place patient identification label above

MHWA120

Instructions to complete this form

- This form must be completed by an Authorised Psychiatrist or Delegate whenever a compulsory patient will be absent overnight or longer periods, and at other times at the discretion of the Authorised Psychiatrist or Delegate.
- The conditions of the leave must specify actions to take in the case of relapse or crisis; including 24-hour contact details (see point 4).

GIVEN NAMES FAMILY NAME (BLOCK LETTERS)

a patient of:

Designated Mental Health Service

who is subject to:

- ☐ an Inpatient Temporary Treatment Order
- ☐ an Inpatient Treatment Order
- ☐ an Inpatient Assessment Order
- ☐ an Inpatient Court Assessment Order.

(please cross ☒ one option only)

1. I **grant** the person leave of absence from: ☐☐ ☐☐ ☐☐☐☐ to: ☐☐ ☐☐ ☐☐☐☐
   date date

   for the purpose of:
   - ☐ treatment
   - ☐ medical treatment
   - ☐ other (please specify):

   (please cross ☒ one option only)

   at:

   name of destination

   address of destination

2. I have had regard to the purpose of the leave and the need to ensure the health and safety of the person and the safety of any other person and the need to minimise the risk of serious harm to those persons.
3. I have given proper consideration to the decision-making principles for treatment and interventions.
4. The conditions of the leave are:

5. I have had regard to :
   - ☐ the views and preferences of the person and their reasons
   - ☐ the person's advance statement of preferences
   - ☐ the views and preferences expressed by the nominated support person
   - ☐ the views of a parent, if the person is under the age of 16 years
   - ☐ the views of any guardian of the person
   - ☐ the views of a carer, if granting leave will directly affect the carer and the care relationship
   - ☐ 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

   please indicate ☒ all persons consulted

Signature: Date: ☐☐ ☐☐ ☐☐☐☐

signature of Authorised Psychiatrist or Delegate

Given Names: Family Name:

Original – medical record *Copy – patient*

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ROLLS AUSTRALIA 1300 600 192

JULY 2023