Mental Health and Wellbeing Act 2022
Sections 555, 556 and 571 - 573

MHWA 156
Transfer of security or forensic patient

Mental Health Statewide UR Number

Local Patient Identifier										

FAMILY NAME

GIVEN NAMES

DATE OF BIRTH	SEX	GENDER

Place patient identification label above

MHWA156

Instructions to complete this form

- This form must be completed by an Authorised Psychiatrist or Delegate.

GIVEN NAMES FAMILY NAME (BLOCK LETTERS)

a patient of:

Designated Mental Health Service

who is:

☐ a Security Patient
☐ a Forensic Patient (excluding Commonwealth forensic patients)
(please cross ☒ one option only)

1. I direct that the abovenamed person be transferred to:

name of receiving Designated Mental Health Service

2. I direct the transfer because:
   ☐ I am satisfied that the transfer is necessary for the person's treatment and I have discussed the transfer with the following Authorised Psychiatrist or Delegate at the receiving Designated Mental Health Service and they approve of the transfer:

name of Authorised Psychiatrist or Delegate consulted Date: (date consulted)

OR

   ☐ the Chief Psychiatrist has directed me to transfer the person because the Chief Psychiatrist is satisfied that the transfer is necessary for the person's treatment.
(please cross ☒ one option only)

3. The reasons for the decision are:

4. I have had regard to:
   ☐ the views and preferences of the person and their reasons
   ☐ the person's advance statement of preference
   ☐ the views and preferences of the nominated support person
   ☐ the views of a parent, if the person is under the age of 16 years
   ☐ the views of a guardian of the person
   ☐ the views of a carer, if the transfer will directly affect the carer and the care relationship
   ☐ the views of the Secretary, Department Families, Fairness and Housing if that Secretary has parental responsibility for the person under a Relevant Child Protection Order;
   ☐ for a Security Patient, the views of the Secretary, Department of Justice and Community Safety.

(please indicate ☒ all persons consulted)

Signature: Date:

signature of Authorised Psychiatrist or Delegate

Given Names: Family Name:

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ROLLS AUSTRALIA 1300 600 192

JULY 2023

Original – medical record