

Mental Health and Wellbeing Act 2022

Sections 153, 170, 200 & 241

MHWA 126

Information to support transport and/or care and control of a patient on a varied 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, Registered Medical Practitioner or an Authorised Mental Health Practitioner to arrange for a person whose Community Order has been varied to an Inpatient Order to be transported to a Designated Mental Health Service.
- This form MUST be accompanied with the MHWA 111 Variation of Temporary Treatment Order or Treatment Order form.
- You must provide 24-hour contact details that an 'Authorised Person' can use to obtain further information or to arrange for the person to be received at the Designated Mental Health Service when they have been apprehended.
- Please cross relevant check boxes in each part.

GIVEN NAMES

FAMILY NAME (BLOCK LETTERS)

a patient of: _____
Designated Mental Health Service

at: _____
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who is subject to:

- an Inpatient Temporary Treatment Order an Inpatient Treatment Order an Inpatient Assessment Order
 Custodial Supervision Order Forensic Remand (please indicate one option only)

1. The above named person was subject to a community order. This order has now been lawfully varied to an inpatient order, and the person must be transported to a Designated Mental Health Service.
Specify the reason why the person has been varied from a community to inpatient setting:

Are there safety concerns for health lead practitioners that requires police assistance? Yes No
If yes, describe

2. Are there current imminent and serious risks? Yes No
If yes, please describe ie: Loss of life, serious physical injury, significant psychological harm or severe neglect resulting in physical or psychological harm.

(Further details may be attached)

3. Description of person:
Sex _____ Gender _____ Height: _____ Weight: _____ Eye colour: _____
Specify other identifying information, such as hair colour, complexion, clothing, tattoos, scars, piercings:
Does the person identify as Aboriginal and/or Torres Strait Islander Yes No

(Further details may be attached)

4. Information that will assist with taking a person into care and control, such as urgency to transport, address where person may be found, typical behaviours, communication strategies, known risks, triggers, medical considerations and details of any support person.:

(Further details may be attached)

5. 24-hour contact details: _____ Telephone: _____
Name of service 24-hour contact number

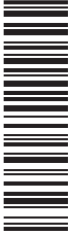
COMPLETED BY

Name: _____ Designation: _____
Authorised Psychiatrist or Delegate, Registered Medical Practitioner or Authorised Mental Health Practitioner

Date:

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Completed MHWA 111 Variation of Temporary Treatment Order or Treatment Order form attached: Yes No



MHWA126

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MAY 2025

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