ANNEXURE

FORM MHCA 01

DEPARTMENT OF HEALTH

REPORT TO MENTAL HEALTH REVIEW BOARD ON PROVISION OF CARE, TREATMENT AND REHABILITATION WITHOUT CONSENT OR EMERGENCY ADMISSION
[Section 9(2) of the Act]

Surname of User ....

First name(s) of User ....

Date of birth ....or estimated age ....

Gender: Male ☐   Female ☐

Occupation ....

Marital status: S ☐   M ☐   D ☐   W ☐

Residential address: ....

....

....

....

....

Date of admission: ....

Time of admission:..................................

Name of health establishment: ....

Reason for admission without consent:

Based on my/practitioners at this health establishment's assessment, any delay in providing care, treatment and rehabilitation services / admission may, due to mental illness, result in:

(a)   the death or irreversible harm to the User

Reasons for this assessment (including mental health status and behavioural reasons) ....

…………………………………………………………………………………

…………………………………………………………………………..

(b)   the User inflicting serious harm to him/herself or others

Reasons for this assessment (including mental health status and behavioural reasons) ....

………………………………………………………………………………….
…………………………………………………………………………………..

(c)   theUser causing serious damage to or loss of property belonging to him/herself or to others

Reasons for this assessment (including mental health status and behavioural reasons) ....
…………………………………………………………………………………..
…………………………………………………………………………………..

I .... (name of mental health care practitioner) hereby declare that I have personally assessed .... (name of mental health care user) at .... (name of health establishment) on ....(date). ....

Designation:…………………………………….
Contact Numbers: ………………………………

……………………………………………
Signature:

Outcome of assessment within 24 hours-

(a)   An application for involuntary or assisted care, treatment and rehabilitation was made─

Date of application .... Time of application......................

(b)   The User agreed to voluntary care, treatment and rehabilitation.

(c)   Patient discharged as a mental health care user .

Print initials and surname...

…………………………………………..
Signature:

(Health care provider ☐ orHead of health establishment   ☐)

Date: ....

(Submit to relevant Review Board)

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