CHIEF PSYCHIATRIST APPROVED FORM – CIVIL 12

PATIENT LEAVE (INVOLUNTARY)

Mental Health Act 2013

Section 60-61

THCI (Patient ID): _____

Family Name: _____

Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT2127 08

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PATIENT LEAVE - Leave Approval OR Leave Refusal OR Leave Cancellation
TO BE COMPLETED BY MEDICAL PRACTITIONER/MEDICAL OR NURSING STAFF

COMPLETE THIS FORM when an application for leave is made verbally or in writing separately for:

- ☐ Part A – Leave Details – To be completed by treating medical practitioner/nursing staff.
- ☐ Part B – Leave Approval / Refusal – To be completed by an approved medical practitioner.
- ☐ Part C - Leave Cancellation – To be completed by an approved medical practitioner.

Note: The request for leave must be noted on the patient's clinical file at the time the request is made.

PERSONAL DETAILS

Patient *(full name in BLOCK letters)*:

Person requesting leave *(print name)*:

Relationship to patient:

PART A – LEAVE DETAILS

To be completed by the treating medical practitioner or nursing staff

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South)
☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Type of leave: ☐ Clinical OR ☐ Personal

From date: DD / MM / YYYY **Time:** 00 : 00 **To date:** DD / MM / YYYY **Time:** 00 : 00

☐ A period or periods to be determined by the patient's treating medical practitioner in accordance with the patient's leave schedule dated: DD / MM / YYYY ☐ Leave schedule attached

Reasons for the leave:

Date of application: DD / MM / YYYY **Time of application:** 00 : 00

Is the medical practitioner completing this form?

☐ **Yes – Medical practitioner to sign here:** _____
(Signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the applicant named above has applied for leave of absence for the patient named above.

1. Dr/Nurse *(full name in BLOCK letters)*:

Signature:	**Date:** DD / MM / YYYY

2. Dr/Nurse *(full name in BLOCK letters)*:

Signature:	**Date:** DD / MM / YYYY

COPY TO: ☐ Patient ☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator
☐ If there is consent – copy to patient support person/representative
☐ If patient is a child copy to parent/support person/representative
☐ If applicable, the patient's escort
☐ Controlling authority of the relevant approved hospital

OTHER: ☐ Statement of Rights provided to patient
☐ Explanation to patient in language and form that patient can understand

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(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PART B: LEAVE APPROVAL / REFUSALLEAVE PASS/NOTICE OF REFUSAL

APPROVED MEDICAL PRACTITIONER TO COMPLETE

Patient *(full name in BLOCK letters)*:

Approved medical practitioner *(full name BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Type of leave: ☐ Clinical OR ☐ Personal

Date of application: DD / MM / YYYY **Time of application:** 00 : 00 ☐ Leave schedule attached

I hereby: ☐ **GRANT** the patient leave from the approved hospital named above (not to exceed 14 days).

From date: DD / MM / YYYY **Time:** 00 : 00 **To date:** DD / MM / YYYY **Time:** 00 : 00

The leave is subject to the following conditions:

OR: ☐ **REFUSE TO GRANT** the patient leave from the approved hospital named above for the following reasons:

Leave granted/refused: **Date:** DD / MM / YYYY **Time:** 00 : 00

Is the approved medical practitioner completing this form?

☐ **Yes – Approved medical practitioner to sign here:** _____

(Signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the applicant named above has applied for leave of absence for the patient named above.

1. Dr/Nurse *(full name in BLOCK letters)*:

Signature: **Date:** DD / MM / YYYY

2. Dr/Nurse *(full name in BLOCK letters)*:

Signature: **Date:** DD / MM / YYYY

PART C: CANCELLATION OF LEAVE

Approved Medical Practitioner *(full name in BLOCK letters)*:

Date leave granted: **Date:** DD / MM / YYYY ☐ Leave pass attached

I hereby cancel the above leave of absence with effect:

☐ Immediately OR ☐ From Date: DD / MM / YYYY Time: 00 : 00

Reason for cancellation:

Date and time leave cancelled: **Date:** DD / MM / YYYY **Time:** 00 : 00

Is the approved medical practitioner completing this form?

☐ **Yes – Approved medical practitioner to sign here:** _____

(Signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the applicant named above has applied for leave of absence for the patient named above.

1. Dr/Nurse *(full name in BLOCK letters)*:

Signature: **Date:** DD / MM / YYYY

2. Dr/Nurse *(full name in BLOCK letters)*:

Signature: **Date:** DD / MM / YYYY

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(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

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PART D: ALERT TO COMMISSIONER OF POLICE

TREATING MEDICAL PRACTITIONER / MEMBERS OF TREATING TEAM TO COMPLETE

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South)

☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Treating medical practitioner *(full name in BLOCK letters)*:

I hereby confirm that the patient named above is subject to an Assessment Order or Treatment Order authorising his or her detention in the above named approved facility and that:

☐ The patient has failed to comply with a condition of leave granted to the patient **OR**

☐ The patient's leave has been cancelled **OR**

☐ The period of leave granted to the patient has expired and the patient has not returned to the approved facility

☐ Leave pass attached ☐ Notice of cancellation *(if relevant)*

☐ The patient is absent without leave from the above named approved facility

☐ Assessment / Treatment Order attached

Is the treating medical practitioner completing this form?

☐ **Yes – Treating medical practitioner to sign here:** _____

(Signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the medical practitioner named above has decided to take the action referred to above:

1. Dr/Nurse *(full name in BLOCK letters)*:

Signature:	**Date:** DD / MM / YYYY

2. Dr/Nurse *(full name in BLOCK letters)*:

Signature:	**Date:** DD / MM / YYYY

COPY TO: ☐ Commissioner of Police or Delegate / MHO / Other escort

☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator

OTHER: ☐ Statement of Rights provided to patient

☐ Explanation to patient in language and form that patient can understand

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PART A : LEAVE DETAILS - *MENTAL HEALTH ACT 2013* – INSTRUCTIONAL NOTES

An involuntary patient's treating team may apply for leave of absence for a patient for clinical or personal reasons. Leave for personal reasons may be requested by the patient or another person who has a genuine interest in the patient's welfare.

PART B: LEAVE APPROVAL/REFUSAL

An approved medical practitioner may grant an involuntary patient leave of absence from an approved hospital for both clinical and personal reasons.

Leave for personal reasons may be granted to a patient at the request of the patient or at the request of a person who, in the opinion of the approved medical practitioner, has a genuine interest in the patient's welfare.

An application can be made verbally and in writing – any request for leave must be documented in the patient's clinical file.

Leave must not be granted for a continuous period of more than 14 days.

Leave may be granted for personal reasons including:

- visiting a sick or dying relative or close friend,
- attending the funeral of a relative or close friend,
- attending a wedding or graduation of a relative or close friend,
- attending a family occasion of special importance,
- leave as part of recovery plan,
- for medical reasons,
- if the patient is Aboriginal or Torres Strait Islander, attendance at an event of cultural or spiritual significance,
- attending a special religious event or service, or
- attending a reunion or commemoration.

A patient who applies for personal leave may ask any staff member of the approved hospital for help in making the request and the staff member is to render that help to the best of their ability or arrange for another staff member of the approved hospital to render that help.

The leave may be granted on such conditions as the approved medical practitioner considers necessary or desirable for the patient's health and safety or the safety of other persons which may include a requirement for the patient to be under escort in which the custody and escort provisions apply.

PART C: CANCELLATION OF LEAVE

Any approved medical practitioner (AMP) may at any time, by notice to a patient, cancel the patient's leave. A notice to cancel leave may take immediate or deferred effect.

PART D - ABSENCE FROM APPROVED HOSPITAL

If any of the following occurs:

- A patient fails to comply with a condition of the leave;
- The leave is cancelled;
- The period of leave expires and the patient has not returned to the approved hospital; and
- The order authorising for the patient's detention in an approved hospital is still in effect.

The treating medical practitioner is to alert TASCAT and may alert the Commissioner of Police of the circumstances (through completion of an approved form).

Any Mental Health Officer or Police Officer may detain the patient as may be required for the purposes of returning the patient to the approved hospital.

CONTACT DETAILS:

Chief Psychiatrist:	Phone: (03) 6166 0778	Email: chief.psychiatrist@health.tas.gov.au
TASCAT – Protective Stream:	Phone: (03) 6165 7491	Email: applications.mentalhealth@tascat.tas.gov.au
Tasmania Police:	Phone 131 444	Email: rds@police.tas.gov.au