

# CHIEF CIVIL PSYCHIATRIST APPROVED FORM I2C



## ABSENCE FROM APPROVED HOSPITAL (INVOLUNTARY)

Mental Health Act 2013  
Section 61

TCHI (Patient ID): \_\_\_\_\_  
 Family Name: \_\_\_\_\_  
 Given Names: \_\_\_\_\_  
 Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Gender:  M  F  TG / IT  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**AFFIX STICKER HERE**

### ALERT TO COMMISSIONER OF POLICE

#### TREATING MEDICAL PRACTITIONER / MEMBERS OF TREATING TEAM TO COMPLETE

A patient's treating medical practitioner may alert the Commissioner of Police or delegate if:

An involuntary patient who has taken leave of absence from an approved hospital fails to comply with a condition of leave, if the leave is cancelled or if the period of leave expires and the patient has not returned to the approved hospital

An involuntary patient is absent from an approved hospital without leave.

Any MHO or Police Officer may take the patient into custody and return the patient to the approved hospital.

**Patient's name:** \_\_\_\_\_

**Approved facility in which the patient is liable to be detained:**

- NWRH (Burnie)  LGH  RHH  Roy Fagan Centre  Millbrook Rise Centre

**Treating medical practitioner's name:** \_\_\_\_\_

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 practitioner to sign here:** \_\_\_\_\_

**No – members of nursing/medical staff to complete:**

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

Dr/Nurse Name/Payroll/ID Number I: \_\_\_\_\_ Signature: \_\_\_\_\_

Dr/Nurse Name/Payroll/ID Number I: \_\_\_\_\_ Signature: \_\_\_\_\_

**COPY TO:**  Commissioner of Police or delegate/MHO/other escort  CCP  MHT  LOC

**CONTACT DETAILS:** MHT: Phone (03) 6165 7491 **CCP: Phone: (03) 6166 0781** [chief.psychiatrist@dhhs.tas.gov.au](mailto:chief.psychiatrist@dhhs.tas.gov.au) **Police:** Phone: (03) 6230 2434 Fax: (03) 6230 2414 Email: [rds@police.tas.gov.au](mailto:rds@police.tas.gov.au)

