CHIEF CIVIL PSYCHIATRIST APPROVED FORM 13

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

INVOLUNTARY PATIENT TRANSFER BETWEEN APPROVED HOSPITALS

Mental Health Act 2013
Section 59

THCI: (Patient Id):

Family Name: _____ Given Name:_____

DOB: _____/_____/_____ Gender: M ☐ F☐ TG/IT☐

Address:

_____

Phone: _____ Mobile: _____

AFFIX STICKER HERE

F1212766

TRANSFER BETWEEN APPROVED HOSPITALS *TRANSFER DIRECTION/ RECORD OF EMERGENCY ORAL DIRECTION*

CHIEF CIVIL PSYCHIATRIST OR DELEGATE TO COMPLETE

The Chief Civil Psychiatrist (CCP) (or delegate) may direct that an involuntary patient be transferred from one approved hospital to another if satisfied that the transfer is necessary for the patient's health or safety or the safety of other persons.

Except in an emergency, the direction is to be in a CCP approved form.

In an emergency, the transfer direction may be given orally or in writing. However, if a transfer direction is given orally, it must be confirmed in writing in a CCP approved form as soon as practicable after it is given.

Once the patient named in the transfer direction has been transferred, an order for the involuntary admission and, if necessary, detention of the patient in the transferring hospital has effect as if it provided for the involuntary admission, and, if necessary, detention of the patient in the other approved hospital.

Patient's name: _____

Approved hospital in which patient is being detained prior to/pending transfer:

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

CCP/delegate's name: _____

I **hereby direct** that the patient named above be transferred from the approved hospital named above to the following approved hospital:

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

I **am satisfied that the transfer is necessary** for *(tick the appropriate box)*:

☐ The patient's health or safety **OR** ☐ The safety of others

Reasons for transfer: _____

_____

Date and time of direction: Date: ____/____/____ Time: _____:_____ (24 hr)

Signature: _____

COPY TO: ☐ Patient ☐ Tribunal ☐ The patient's treating medical practitioner ☐LOC ☐ Controlling authority of the sending approved hospital ☐ Controlling authority of the receiving approved hospital ☐ If the patient is a child or if there is consent - copy to parent/support person/representative

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

CONTACT DETAILS: **MHT:** Phone: (03) 6165 7491 Email: mht.applications@justice.tas.gov.au

CCP: Phone: (03) 6166 0781 Email: chief.psychiatrist@dhhs.tas.gov.au