FORM MHCA 10

DEPARTMENT OF HEALTH

TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER - SCHEDULE OF CONDITIONS RELATING TO HIS OR HER INVOLUNTARY OUTPATIENT CARE, TREATMENT AND REHABILITATION SERVICES
[Section 34(3)(b) or (5) 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: .....
.....
.....
.....
.....
Name of custodian into whose charge the User is discharged: .....
.....
Address of custodian: .....
.....
.....
.....
.....

i. The User's mental health status will be monitored and reviewed at ..... (name of health establishment)

ii. The User is to present him / herself to this health establishment every .....weeks / months to have his or her mental health status reviewed.

iii. Name of health establishment(s) where involuntary mental health care, treatment and rehabilitation will be provided on an outpatient basis if different from preceding health establishment: .....

iv. Conditions of behaviour which must be adhered to by the User:……...
.....
.....
.....
.....
.....

Name of psychiatric hospital and/or care and rehabilitation centre where the User is to be admitted if he / she relapses to the extent of being a danger to him / herself or others if he / she remains an involuntary outpatient, or to which he / she is to be admitted if the conditions of outpatient care are violated .....
(name of health establishment)
Print initials and surname .....……...
……..
Signature(head of health establishment)

Date: .....
Place: .....……

…….
Signature of User (understands and accepts the stipulated conditions)

……
Signature of custodian (understands and accepts the stipulated conditions)

[Original to Review Board and copy toUser, custodian and head of health establishment to whom User was referred on outpatient basis]