



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

MHCA 10

**TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER –
SCHEDULE OF CONDITIONS RELATING TO HIS OR HER OUTPATIENT CARE,
TREATMENT AND REHABILITATION**
[Sections 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:

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

The user is to present him / ~~herself~~ to this health establishment every weeks /
~~months~~ to be monitored and have his ~~or her~~ mental health status reviewed.



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:

Conditions of behaviour which must be adhered to by the user:

.....
.....
.....
.....
.....

Name of psychiatric hospital / ~~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: *[Handwritten signature]*
(head of health establishment)

Date:

Place:

Signature of user: *[Handwritten signature]*
(understand and accept the stipulated conditions)

Signature of custodian: *[Handwritten signature]*
(understand and accept the stipulated conditions)

[Copy to Review Board, user, custodian and head of health establishment to whom user was referred on outpatient basis]