FORM MHCA 05

DEPARTMENT OF HEALTH

REPORT ON COMPLETION OF EXAMINATION AND FINDINGS BY MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION FOR ASSISTED OR INVOLUNTARY CARE TREATMENT AND REHABILITATION
[Section 27(5) or 33(5) of the Act]

Section 1
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: .....
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Section 2
Date of examination: ..... Place of examination: .....
Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health:
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.....

(b) Are there signs of injuries? Yes☐ No☐
If yes, please indicated whether you believe this is as a result of abuse?

Yes☐ No☐ Unsure☐

If yes, was this abuse reported/investigated? Yes☐ No☐

(c) Are there signs of communicable diseases? Yes☐ No☐

If the answer to (b) or (c) is Yes, give further particulars:

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Section 3

Information on User received from other person(s) or family (state names and contact details):

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Section 4

Previous mental health history if known (State dates and places):

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Section 5

Mental health status of the User at the time of the present examination (describe symptoms or diagnostic criteria):

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Section 6

Type of illness (provisional diagnosis):

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Section 7

In my opinion the above-mentioned User—

has homicidal tendencies due to mental illness Yes☐ No☐

has suicidal tendencies due to mental illness Yes☐ No☐
is a risk to inflicting serious harm to him/herself or others or causing serious damage to property belong to him/her or other due to mental illness Yes☐ No☐

Section 8
Recommendation to head of health establishmenton an application for assisted care, treatment and rehabilitation services only**(do not complete section 9 of this form if section 8 is applicable)—**
An application was made for assisted care, treatment and rehabilitation services□ or involuntary care□, treatment and rehabilitation services ☐

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services for their ownhealth and safety or the health and safety of others? Yes☐ No☐

2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes☐ No☐

3. Is the User willing to receive care, treatment and rehabilitation services? Yes☐ No☐

Section 9
Recommendation to head of health establishment on anapplication for Involuntary care, treatment and rehabilitation services only **(Do not complete section 8 of this form if section 9 is applicable)**

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services?Yes☐ No☐
2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services?Yes☐ No☐
3. Does the User refuse to receive care, treatment andrehabilitation services? Yes☐ No☐
4.Is the User in your view,likely to inflict serious harm on him/herself or others? Yes☐ No☐

5.Is care, treatment and rehabilitation services, in your view necessaryfor the protection of the User's financial interests or reputation? Yes☐ No☐

Section 10

Based on the abovementioned information my recommendation to the head of health establishment is that the User should—

1. Receive voluntary care, treatment and rehabilitation services☐

2. Receive assisted in-patient care, treatment and rehabilitation services ☐

3. Undergo 72 hour assessment following the application for involuntary care, treatment and rehabilitation services to determine the need for further care, treatment and rehabilitation services ☐

Section 11

I declare that I have personally informed the mental health care User of his/her rights, including his/her right to representation including the right to legal representation and/or Legal Aid, and the right to have his/her financial interests or reputation safeguarded and his/her right to have an administrator or curator appointed.

Comment:

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I ..... (name of mental health care practitioner) hereby declare that I have personally assessed .... (name of mental health care user) at .... (name of health establishment) on ..... (date).

.....

Signature:.....

Category of designated mental health care practitioner: .....

Registration number with relevant Council:.....

Date: .....

Place: .....