CHIEF CIVIL PSYCHIATRIST APPROVED FORM 11

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

APPLICATION FOR PERSONAL LEAVE

Mental Health Act 2013
Sections 60 - 61

THCI: (Patient Id):

Family Name: _____ Given Name:_____

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

Address: _____

Phone: _____ Mobile: _____

AFFIX STICKER HERE

FT21270 4L

APPLICATION FOR PERSONAL LEAVE
APPLICATION

PATIENT OR PERSON WITH GENUINE INTEREST IN THE PATIENT'S WELFARE TO COMPLETE

Patient's name:

_____

Approved facility in which the patient is being detained:

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

Leave for personal reasons may be granted only on the application of the patient, or a person who, in the opinion of the approved medical practitioner considering the application, has a genuine interest in the patient's welfare.

Leave must not be granted for a continuous period of more than 14 days.

Leave may be granted for personal reasons including visiting a sick or dying relative or close friend, attending the funeral of a relative or close friend, attending a wedding or graduation of a relative or close friend, attending a family occasion of special importance, if the patient is an Aborigine - attending an event of cultural or spiritual significance to Aborigines, attending a special religious event or service, or attending a reunion or commemoration.

A patient who applies for personal leave may ask any staff member of the approved hospital for help in making the request and the staff member is to render that help to the best of his or her ability, or arrange for another staff member of the approved hospital to render that help.

Who is applying for the leave?

☐ The patient **OR**

☐ Another person. Name and nature of the person's interest in the patient's welfare:

_____

_____

Period of leave sought:

☐ **From:** Date: / / Time: ____:____ (24 hr) **To:** Date: / / Time: _____:_____ (24 hr)

Reason(s) for the leave:

_____

_____

_____

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

Is the applicant completing the form?

☐ **Yes – applicant to sign here:** _____

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

We, the undersigned, confirm that the applicant named above has applied for Leave of Absence for the patient named above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 2: _____ Signature: _____

Other: ☐ If the patient is the applicant and has sought help to make this application – the patient has been given the help sought