

CHIEF CIVIL PSYCHIATRIST APPROVED FORM I2A



Rights, Respect, Recovery

**LEAVE GRANTED/
REFUSED
(INVOLUNTARY)**

Mental Health Act 2013
Section 60

THCI: (Patient Id): _____

Family Name: _____ Given Name: _____

DOB: ____/____/____ Gender: M F TG/IT

Address: _____

Phone: _____ Mobile: _____

AFFIX STICKER HERE

LEAVE GRANTED/REFUSED

LEAVE PASS/NOTICE OF REFUSAL

APPROVED MEDICAL PRACTITIONER TO COMPLETE

Any approved medical practitioner (AMP) may grant an involuntary patient leave of absence from an approved hospital.

The leave may be granted for personal or clinical reasons.

However, leave must not be granted for a continuous period of more than 14 days. The leave is to be granted by means of an instrument in writing (leave pass).

The leave may be granted on such conditions as the AMP considers necessary or desirable for the patient's health or safety or the safety of other persons. This may include a requirement that the patient be under escort during the leave or any portion of the leave (in which case the custody and escort provisions apply).

The AMP is to ensure that the conditions of leave are specified in the leave pass.

An AMP who refuses an application for leave is to give notice of the refusal, with reasons, to the applicant and to the patient, if the applicant was someone other than the patient, together with a Statement of Rights.

Patient's name: _____

Approved facility in which the patient is being detained:

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

Type of leave applied for: Clinical **OR** Personal.

Applicant's name: _____

Date of application: ____ / ____ / ____

AMP's name: _____

I hereby (tick appropriate box and complete the relevant section):

GRANT the patient named above leave from the approved hospital named above:

From: Date: ____ / ____ / ____ Time: ____:____ (24 hr)

To: Date: ____ / ____ / ____ Time: ____:____ (24 hr)

For the period or periods set out in the patient's leave schedule dated ____ / ____ / ____

Leave schedule attached

If the leave is personal leave and if the applicant is a person other than the patient, I **also confirm** that I am satisfied that the applicant has a genuine interest in the patient's welfare.

The leave is subject to the following

conditions: _____

Date and time leave granted: Date: ____ / ____ / ____ Time: ____:____ (24 hr)

REFUSE TO GRANT the patient named above leave from the approved hospital named above, for the following reasons:

Date and time leave refused: Date: ____ / ____ / ____ Time: ____:____ (24 hr)

Is the AMP granting/refusing the leave completing this form?

Yes – AMP to sign here: _____

No – members of nursing/medical staff to complete:

We confirm that the AMP named above has granted/refused the patient named above leave of absence from the approved hospital referred to above, as outlined in this leave pass/notice of refusal:

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

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

COPY TO: Patient If leave is refused and the applicant is someone other than the patient – the applicant Controlling authority of the approved hospital If the patient is required to be under escort - MHO/other escort Tribunal CCP LOC If the patient is a child or if there is consent – the patient's parent/support person/representative

OTHER: Statement of Rights to patient If leave is refused and the applicant is someone other than the patient - Statement of Rights to applicant Explanation to patient in language and form that s/he can understand

CONTACT DETAILS: MHT: Ph: (03) 6165 7491 mht.applications@justice.tas.gov.au CCP: Ph: (03) 6166 0781 chief.psychiatrist@dhhs.tas.gov.au