Province of Alberta

MENTAL HEALTH ACT

MENTAL HEALTH ACT
FORMS REGULATION

Alberta Regulation 136/2004

With amendments up to and including Alberta Regulation 147/2017

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Note

All persons making use of this consolidation are reminded that it has no legislative sanction, that amendments have been embodied for convenience of reference only. The official Statutes and Regulations should be consulted for all purposes of interpreting and applying the law.

(Consolidated up to 147/2017)

ALBERTA REGULATION 136/2004

Mental Health Act

MENTAL HEALTH ACT FORMS REGULATION

Table of Contents

Interpretation

1(1) In this Regulation,

(a) "Act" means the *Mental Health Act*;

(b) "appropriate regional health authority" means the regional health authority of the region in which the person who is subject to a community treatment order normally resides;

(c) "issuing psychiatrist" means the psychiatrist, or the physician designated in accordance with section 9.7 of the Act, who last issued, renewed or amended a community treatment order.

(2) A reference in this Regulation to a form is to a form in the Schedule.

AR 136/2004 s1;342/2009

Admission certificate

2 An admission certificate under section 2 of the Act must be in Form 1.

Renewal certificate

3 A renewal certificate under section 8 of the Act must be in Form 2.

Order to return patient

4 An order under section 20(4) or section 21(1) of the Act to return a formal patient to a facility must be in Form 3.

Transfer into Alberta

5 A certificate under section 24(1) of the Act authorizing the apprehension and conveyance of a person who comes or is brought into Alberta to a facility for examination must be in Form 4.

Transfer out of Alberta

6 A transfer under section 25 of the Act authorizing the transfer of a formal patient to a jurisdiction outside Alberta must be in Form 5.

Transfer to another facility

7 A memorandum of transfer under section 22(1) of the Act authorizing the transfer of a formal patient to another facility must be in Form 6.

Information

8 An information under section 10 of the Act must be in Form 7.

Warrant

9 A warrant under section 10 of the Act directing a peace officer to apprehend and convey a person to a facility for examination must be in Form 8.

Extension of warrant

10 An order under section 11 of the Act extending the duration of a warrant must be in Form 9.

Statement of peace officer

11 The statement under section 12 of the Act of a peace officer who conveys a person to a facility must be in Form 10.

Application re competence

12(1) A certificate under section 27(1) of the Act must be in Part One of Form 11.

(2) A notice of the board under section 27(3) must be in Part Two of Form 11.

(3) A notice of application under section 27(3) of the Act to have a physician's opinion reviewed by a review panel must be in Form 12.

(4) A notice of hearing under section 40(2) of the Act that the chair of a review panel must give on receipt of an application under section 27 of the Act must be in Form 13.

(5) A report of a decision of a review panel under section 41 of the Act relating to an application under section 27 of the Act must be in Form 14.

Application re treatment

13(1) An application under section 29(2) of the Act for an order directing that treatment may be administered to a formal patient must be in Form 12.

(2) A notice of hearing under section 40(2) of the Act that the chair of a review panel must give on receipt of an application under section 29 of the Act must be in Form 13.

(3) A report of the decision of a review panel under section 41 of the Act relating to an application under section 29 of the Act must be in Form 15.

Application re transfer back to correctional facility

14(1) An application under section 33 of the Act for an order transferring a person back to a correctional facility must be in Form 12.

(2) A notice of hearing under section 40(1) of the Act that the chair of a review panel must give on receipt of an application under section 33 of the Act must be in Form 13.

(3) A report of the decision of a review panel under section 41 of the Act relating to an application under section 33 of the Act must be in Form 16.

Application for cancellation

15(1) An application under section 38 of the Act for cancellation of admission certificates, renewal certificates or community treatment orders must be in Form 12.

(2) A notice of hearing under section 40(1) of the Act that the chair of a review panel must give on receipt of an application under section 38 of the Act or with respect to a deemed application under section 39 of the Act must be in Form 13.

(3) A report of a decision of a review panel under section 41 of the Act relating to an application under section 38 of the Act must be in Form 17.

(4) A report of a decision of a review panel under section 41 of the Act relating to a deemed application under section 39 of the Act must be in Form 18.

AR 136/2009 s15;342/2009

Community treatment order forms

15.1(1) A community treatment order must be issued in Form 19.

(2) A community treatment order must be renewed in Form 20.

(3) An amendment to the treatment or care plan set out in the community treatment order must be in Form 21.

(4) Notice of the cancellation or expiry of a community treatment order must be in Form 22.

(5) An order for the apprehension of a person who is subject to a community treatment order under section 9.6 of the Act must be in Form 23.

(6) An examination of a person who is subject to a community treatment order and who has been apprehended under section 9.6 of the Act must be recorded in Form 24.

(7) A designation of a physician under section 9.7 of the Act must be in Form 25.

(8) A written statement in respect of the issuance, renewal or amendment of a community treatment order for the purposes of section 14(1.1)(a) of the Act must be in Form 26.

(9) A report by a treatment or care provider that a person who is subject to a community treatment order has failed to comply with the treatment and care plan in the community treatment order must be in Form 27.

AR 342/2009 s4

16 Repealed AR 14/2009 s4.

Repeal

17 The *Forms and Review Panels Regulation* (AR 338/89) is repealed.

Expiry

18 For the purpose of ensuring that this Regulation is reviewed for ongoing relevancy and necessity, with the option that it may be repassed in its present or an amended form following a review, this Regulation expires on November 30, 2020.

AR 136/2004 s18;190/2011;147/2017

Schedule

Form 1

Admission Certificate

Mental Health Act

Section 2

I, (print name of physician) of (address), certify that I personally examined (print name of person examined) of (home address) on (date) at (time) at (place of examination).

In my opinion the person examined is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable for admission to a facility other than as a formal patient.

(Note: All three criteria above must be met.)

I have formed my opinion

(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

(Note: (a) and (b) must be completed.)

☐ The person is not in a facility and is to be conveyed for examination to (name of facility) at (address of facility).

(Place an X in the box if conveyance is required.)

(date of issue)

(time of issue)

(signature of physician)

(printed name of physician)

Form 2

Renewal Certificate

Mental Health Act

Section 8

I, (print name of physician) of (address), certify that I personally examined (print name of person examined) on (date) at (time) separately from any other physician.

In my opinion the person examined is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable to continue at a facility other than as a formal patient.

(Note: All three criteria above must be met.)

I have formed my opinion

(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

(Note: (a) and (b) must be completed.)

The person was examined at (name of facility)

(date of issue)_____

(time of issue)_____

(signature of physician)_____

(printed name of physician)_____

Form 3

Order to Return a Formal Patient to a Facility

Mental Health Act

Section 20(4) or 21(1)

To all or any peace officers in Alberta:

(name of formal patient), a formal patient, is absent without leave pursuant to the *Mental Health Act.*

You are hereby ordered to return the formal patient to (name and address of facility).

Admission certificates (or renewal certificates) expire on (date) .

Dated this ____ day of _____, 20__.

(signature of representative of board of facility)_____

(printed name of representative)

Form 4

Certificate of Transfer into Alberta

Mental Health Act

Section 24(1)

I have reasonable and probable grounds to believe that (full name of person) may come or be brought into Alberta and is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable for admission to a facility other than as a formal patient.

(Note: All three criteria above must be met.)

Pursuant to section 24(1) of the *Mental Health Act*, I authorize a peace officer or (name of person authorized) to apprehend and convey (full name of person) to a facility for examination.

(date of issue)_____

(signature of the Minister of Health or person designated by the Minister of Health)_____

(printed name of Minister of Health or designated person)_____

Form 5

Transfer of Formal Patient to a Jurisdiction Outside Alberta

Mental Health Act

Section 25

It appears to me

☐ that (name of formal patient) has come or been brought into Alberta and that his/her care and treatment is the responsibility of (name of other jurisdiction).

or

☐ that it would be in the best interests of (name of formal patient) to be cared for in (name of other jurisdiction).

(Choose one and place an X in the appropriate box.)

Therefore, I authorize that (name of formal patient) be transferred to (name of other jurisdiction).

(date of issue)_____

(signature of the Minister of Health or person designated by the Minister of Health)_____

(printed name of Minister of Health or designated person)_____

Form 6

Memorandum of Transfer to Another Facility

Mental Health Act

Section 22(1)

Arrangements have been made with the board of (name of facility to which the patient is to be transferred) to transfer (name of formal patient), a formal patient in (name of facility in which patient is presently detained), to (name of facility to which the patient is to be transferred).

Dated this ___ day of _____, 20__.

(signature of representative of board of sending facility)_____

(printed name of representative)__

Form 7

Information

Mental Health Act

Section 10

This is the information of (name of informant) of (address of informant) who says that he/she has reasonable and probable grounds to believe that (name of person) of (address of person) is

☐ suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or

☐ is subject to a community treatment order and is not complying with the order.

SWORN BEFORE ME at the _____ of _____, in the Province of Alberta, the ____ day of _____, 20_____.

_____ (signature of informant)

(Judge of The Provincial Court of Alberta)

(printed name of informant)

Form 8

Warrant

Mental Health Act

Section 10

To all or any peace officers in Alberta:

(name of informant) has brought before me an information on oath that (name of person) of (address of person)

☐ is suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or

☐ is subject to a community treatment order and is not complying with the order.

I am satisfied that (name of person)

☐ is suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or

☐ is subject to a community treatment order and is not complying with the order,

and that an examination can be arranged in no way other than by apprehension.

This is to order you to apprehend (name of person) and convey him/her to a facility for an examination.

Brief reasons:

Dated this ___ day of _____, 20__ at _____.

(signature of Judge of The Provincial Court of Alberta)

(printed name of Judge of The Provincial Court of Alberta)

(clerk of the Court)

(date of filing)

Form 9

Extension of Warrant

Mental Health Act

Section 11

To all or any peace officers in Alberta:

(name of Judge of The Provincial Court of Alberta) issued a warrant dated _____ to apprehend (name of person).

The warrant has not been executed.

(name of peace officer), (badge number) of (detachment),

☐ has appeared before me to apply for an extension of the warrant.

or

☐ has applied for an extension of the warrant by telephone or other means of telecommunication, and it appears on the oath of (name of peace officer) that it is impracticable to appear before me personally and that there are reasonable grounds for dispensing with an information presented personally and in writing.

(Choose one and place an X in the appropriate box.)

This order therefore extends the duration of the warrant for a period of 7 days from the day on which the warrant expires.

Dated at (place) on the ___ day of _____, 20__ at (time) .

(signature of Judge of The Provincial Court of Alberta)

(printed name of Judge of The Provincial Court of Alberta)

(clerk of the Court)

(date of filing)

Form 10

Statement of Peace Officer on Apprehension

Mental Health Act

Section 12

(name of person apprehended, if known) was apprehended on (date) at (time).

He/She was apprehended at (describe place and address).

I have reasonable and probable grounds to believe that

(a) the person apprehended is suffering from mental disorder,

(b) the person apprehended is

☐ likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment,

or

☐ subject to a community treatment order and is not complying with the community treatment order,

(c) the person apprehended should be examined in the interests of his/her own safety or the safety of others, and

(d) the circumstances are such that to proceed under section 10 of the *Mental Health Act* would be dangerous.

(Note: All four criteria above must be met.)

The grounds for my belief are:

Dated this ___ day of _____, 20__.

(signature of peace officer)

(printed name of peace officer)

(badge number)

(detachment)

Form 11

Certificate of Incompetence to Make Treatment Decisions

Mental Health Act

Section 27

Part One

(To be completed by a physician)

I, (name of physician), am of the opinion that (name of formal patient) is not mentally competent to make treatment decisions.

The reasons for my opinion are as follows: _____.

Dated this ___ day of _____, 20__.

(signature of physician)

(printed name of physician)

Part Two

(To be completed by the board of a facility)

To: (name of formal patient) of (address)

And: (name of patient's guardian or agent, if any) of (address)

And: (name of nearest relative, unless patient objects) of (address)

Take notice that (name of formal patient) is entitled to have the physician's opinion about his/her competence to make treatment decisions reviewed by a review panel by sending to the chair of the review panel an Application for Review Panel Hearing, in Form 12.

Dated this ____ day of _____, 20__.

(signature of representative of board of facility)

(printed name of representative)

Form 12

Application for Review Panel Hearing

Mental Health Act

Sections 27(3), 29(2), 33 and 38(1) and (1.1)

To: (print name of chair of the review panel)
(address of chair) _____

I, (printed name of applicant) of (printed address of applicant), bearing a relationship of (self, relative, guardian, agent, physician, other) to (name of patient or person who is subject to a community treatment order), apply

☐ under section 27(3) of the Act for a review of the attached Certificate of Incompetence to Make Treatment Decisions, dated _____
and signed by _____.

☐ under section 29(2) of the Act for an order directing that the following treatment (nature of treatment) be administered to (name of formal patient).

☐ under section 33 of the Act for an order transferring (name of patient) back to (name of correctional facility).

☐ under section 38(1) of the Act for cancellation of admission certificates or renewal certificates issued on (date of issue).

☐ under section 38(1.1) of the Act for cancellation of the community treatment order (issued/amended/renewed) on (date of issue/amendment/renewal).

(Choose one and place an X in the appropriate box.)

Dated this ___ day of _____, 20__.

(signature of applicant)

Notice

Mental Health Act

I (do) (do not) object to my nearest relative being informed of the review panel hearings.

(signature of patient or person who is subject to community treatment order)

(printed name of patient or person who is subject to community treatment order)

Form 13

Notice of Hearing Before Review Panel

Mental Health Act

Section 40

Application received by the review panel (date)

Take notice that a hearing will be held

(Choose one and place an X in the appropriate box.)

☐ under section 27(3) of the Act for a review of the physician's opinion in the attached Certificate of Incompetence to Make Treatment Decisions relating to (name of formal patient) dated _____ and signed by _____.

☐ under section 29(2) of the Act for an order directing that the following treatment (nature of treatment) may be administered to (name of formal patient).

☐ under section 33 of the Act for an order transferring (name of patient) back to a correctional facility.

☐ under section 38(1) of the Act for cancellation of admission certificates or renewal certificates relating to (name of formal patient).

☐ under section 38(1.1) of the Act for cancellation of the community treatment order (issued/amended/renewed) on (date of issue/amendment/renewal).

☐ under section 39 of the Act for

(Choose one and place an X in the appropriate box.)

☐ cancellation of renewal certificates relating to (name of formal patient), or

☐ cancellation of the community treatment order relating to (name of person who is subject to the community treatment order).

The review panel will hear the application on (date) at (time) at (place).

(date of issue)_____

(signature of chair of review panel)_____

(printed name of chair)_____

(address)_____

Form 14

Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions

Mental Health Act

Sections 27(3) and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of formal patient) and has decided

☐ to cancel the attached Certificate of Incompetence to Make Treatment Decisions dated _____ and signed by _____.

☐ to refuse to cancel the attached Certificate of Incompetence to Make Treatment Decisions dated _____ and signed by _____.

(Place an X in the appropriate box.)

Date of decision: _____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 15

Decision of Review Panel Regarding Treatment

Mental Health Act

Sections 29(2) and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of board representative or physician) and has decided

☐ to make an order authorizing the following treatment (nature of treatment) to be administered to (name of formal patient).

☐ to refuse to make an order authorizing the following treatment (nature of treatment) to be administered to (name of formal patient).

(Place an X in the appropriate box.)

Date of decision: _____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 16

Decision of Review Panel Regarding Transfer Back to a Correctional Facility

Mental Health Act

Sections 33 and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of applicant) and has decided

☐ to order that (name of patient) be transferred back to (name of correctional facility).

☐ to refuse to make an order.

☐ to cancel the admission certificates or renewal certificates, if any.

☐ to refuse to cancel the admission certificates or renewal certificates for the following reasons: _____.

(Place an X in the appropriate box(es).)

Date of decision: _____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 17

Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders

Mental Health Act

Sections 38(1) and (1.1) and 41

(name of formal patient or person who is subject to the community treatment order) (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of applicant), bearing a relationship of (self, agent, guardian, other) to (name of formal patient or person who is subject to the community treatment order), and has decided

☐ to cancel the admission certificates or renewal certificates relating to the person named above.

☐ to refuse to cancel the admission certificates or renewal certificates relating to the person named above for the following reasons: _____.

☐ to cancel the community treatment order relating to the person named above.

☐ to refuse to cancel the community treatment order relating to the person named above for the following reasons: _____.

(Place an X in the appropriate box.)

Date of decision: _____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 18

Decision of Review Panel Regarding Renewal Certificates and Community Treatment Orders (Deemed Application)

Mental Health Act

Sections 39 and 41

(name of formal patient or person who is subject to the community treatment order) (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered an application deemed by section 39 of the Act to have been made by (name of formal patient or person who is subject to community treatment order) and has decided

☐ to cancel the renewal certificates relating to the person named above.

☐ to refuse to cancel the renewal certificates relating to the person named above for the following reasons: _____.

☐ to cancel the community treatment order relating to the person named above.

☐ to refuse to cancel the community treatment order relating to the person named above for the following reasons: _____.

(Place an X in the appropriate box.)

Date of decision: _____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 19

Issuance of Community Treatment Order

Mental Health Act

Section 9.1

PART I
Issuing Psychiatrist's Examination

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am:

☐ a psychiatrist;

OR

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the issuance of this community treatment order,

and I am the issuing psychiatrist of this community treatment order.

I certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, is suffering from mental disorder,

(b) has

☐ during the immediately preceding 3-year period, on 2 or more occasions, or for a total of at least 30 days,

☐ been a formal patient in a facility,

☐ been in an approved hospital or been lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section

2(a) and (b) of the *Mental Health Act* at the time or those times,

☐ both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

or

☐ within the immediately preceding 3-year period, been subject to a community treatment order,

or

☐ in my opinion while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

_____.

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

_____ _____

(signature of issuing psychiatrist) (date and time)

PART II
Second Examination by Physician

Name of person: _____

Address (if known): _____

Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

I, (print name of physician) of (business address), certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, is suffering from mental disorder,

(b) has

☐ during the immediately preceding 3-year period, on 2 or more occasions, or for a total of at least 30 days,

☐ been a formal patient in a facility,

☐ been in an approved hospital or been lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

☐ both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

or

☐ within the immediately preceding 3-year period, been subject to a community treatment order,

or

☐ in my opinion, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

_____.

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

_____ _____
(signature of physician) (date and time)

PART III
Treatment and Care Plan

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

☐ _____,

or

☐ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: _____ Contact Phone Number: _____
Profession/Role: _____
Description of Treatment or Care:

_____

_____

Location (if applicable): _____

Date/Time or Frequency (if applicable): _____

_____ _____
(signature of provider or person authorized by regional health authority) (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations
In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

PART IV

Person Responsible for Supervision of

Community Treatment Order

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

The person responsible for the supervision of this community treatment order is

☐ the issuing psychiatrist, or

☐ (name of physician who is responsible for the supervision of community treatment order)

I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

_____ _____
(signature of issuing psychiatrist or supervising physician) (date)

PART V
Consent

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

☐ **Consent by person who is subject to community treatment order**

I, _____, am the person subject to this community treatment order and I consent to the issuing of this community treatment order.

_____
(signature)

_____
(date)

☐ **Consent by substitute decision-maker**

I, (print name of substitute decision-maker) am the person authorized under section 28(1) of the *Mental Health Act* to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the issuing of this community treatment order.

_____
(signature of substitute decision-maker)

_____
(date)

☐ **No consent**

I, the issuing psychiatrist, have not obtained consent to the issuing of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the issuance of a community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

_____
(signature of issuing psychiatrist)

Form 20

Renewal of Community Treatment Order

Mental Health Act

Section 9.3

Name of person:_____
Address (if known): _____
Phone (if known):_____
Date of Birth: _____ Personal Health Care Number: _____

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am:

☐ a psychiatrist;

OR

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act* and I confirm I have consulted with a psychiatrist prior to the renewal of this community treatment order,

and I am the issuing psychiatrist in relation to the renewal of this community treatment order.

I certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, continues to suffer from mental disorder,

(b) is currently subject to a community treatment order,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:
_____.

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

_____ _____
(signature of issuing psychiatrist) (date and time)

PART II
Second Examination by Physician

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

I, (print name of physician) of (business address), (phone number), certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, continues to suffer from mental disorder,

(b) is currently subject to a community treatment order,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:
_____.

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

_____ _____
(signature of physician) (date and time)

PART III
Treatment and Care Plan

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

☐ _____

OR

☐ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: _____ Contact Phone Number: _____
Profession/Role: _____
Description of Treatment or Care:

_____
Location (if applicable): _____
Date/Time or Frequency (if applicable): _____

_____ _____
(signature of provider or person authorized by regional health authority) (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations
In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

PART IV

Person Responsible for Supervision of Community Treatment Order

Name of person: _____
Address (if known): _____

Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

The person responsible for the supervision of this community treatment order is

☐ the issuing psychiatrist, or

☐ (name of physician who is responsible for the supervision of community treatment order)

I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

_____ _____
(signature of issuing psychiatrist or supervising physician) (date)

PART V

Consent

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

☐ **Consent by person who is subject to community treatment order**

I, _____, am the person subject to this community treatment order and I consent to the renewal of this community treatment order.

_____
(signature) (date)

☐ **Consent by substitute decision-maker**

I, (print name of substitute decision-maker) , am the person authorized under section 28(1) of the *Mental Health Act* to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the renewal of this community treatment order.

_____
(signature of substitute decision-maker)

_____
(date)

☐ **No consent**

I, the issuing psychiatrist, have not obtained consent to the renewal of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while

living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the renewal of the community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

_____ _____
(signature of issuing psychiatrist) (date)

Form 21

Community Treatment Order

Amendments to Community Treatment Order

Mental Health Act

Section 9.4

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of birth: _____ Personal Health Care Number _____

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am

☐ a psychiatrist;

or

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act* and I confirm I have consulted with a psychiatrist prior to the amendment of this community treatment order,

and I am the issuing psychiatrist of this amended community treatment order.

I amend the community treatment order for this person by

☐ amending the name of the person responsible for supervision of the community treatment order as follows:

Effective on the date below I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

_____ _____
(signature of supervising physician) (effective date)

☐ amending the treatment and care plan as follows:

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted according to clinical need):

☐ _____

OR

☐ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: _____ Contact Phone Number: _____
Profession/Role: _____
Description of Treatment or Care:
_____
Location (if applicable): _____
Date/Time or Frequency (if applicable): _____

_____
(signature of provider or person authorized by regional health authority) (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

3. the person who is subject to the community treatment order is no longer required to _____.

I have explained the above amendment(s) to

☐ the person who is subject to this community treatment order,

or

☐ the substitute decision-maker for the person who is subject to this community treatment order.

_____ _____
(signature of psychiatrist or designated physician) (date)

Reporting obligations
In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

Form 22

Community Treatment Order

Cancellation or Expiry

Mental Health Act

Section 9.5

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

☐ Cancellation of community treatment order

I, (name of psychiatrist or designated physician) of (business address), (phone number), am:

☐ a psychiatrist,

or

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the cancellation of this community treatment order,

AND

I cancel this person's community treatment order because this person no longer meets the criteria specified in section 9.1(1)(b) to (d) of the *Mental Health Act*.

☐ Expiry of community treatment order

This person's community treatment order has expired.

Continued treatment recommendation (if applicable):

I recommend continued treatment and care as follows:

_____

_____ _____

(signature of physician) (date and time)

Notice:
You are no longer subject to a community treatment order effective on the date and time written above. However, this form may contain information about treatment and care that your health care provider is recommending you continue to receive.

Form 23

Community Treatment Order

Apprehension Order

Mental Health Act

Section 9.6

To all or any peace officers in Alberta:

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of birth: _____

To all or any peace officers in Alberta:

I, (name of psychiatrist or designated physician) of (business address), (phone number), am:

☐ a psychiatrist;

OR

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the issuance of this apprehension order,

and I have reasonable grounds to believe that (name of person who is subject to community treatment order) has failed to comply with his/her community treatment order. The reasons for my belief are as follows:

_____.

I am satisfied that efforts that are reasonable in the circumstances have been made to

(a) inform the person who is named in this order that the person has failed to comply with the person's community treatment order,

(b) inform the person of the possibility that I may issue an order for apprehension and assessment of the person if the person continues to fail to comply with the community treatment order, and of the possible consequences of that assessment, and

(c) provide reasonable assistance to the person to comply with the community treatment order,

and that the person continues to fail to comply with his/her community treatment order.

This authorizes you to

(a) apprehend the person who is named in this order and to convey the person to (name of facility) for an examination,

(b) take reasonable measures, including the entering of premises and the use of physical restraint, to apprehend the person who is named in this order and to take the person into custody for the purpose of conveying the person to the facility, and

(c) while the person is being conveyed to the facility, to care for, observe, detain and control the person.

_____ _____

(signature of psychiatrist or designated physician) (date and time)

This apprehension order expires 30 days after the date of issue.

Form 24

Community Treatment Order

Examination on Apprehension

Mental Health Act

Section 9.6

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of birth: _____ Personal Health Care Number: _____

I, (print name of psychiatrist, physician or designated physician) of (business address), (phone number), am:

☐ a psychiatrist,

OR

☐ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist respecting this community treatment order,

OR

☐ a physician,

and I certify that I personally examined this person on (date) at (time) at (place of examination) and have determined that

☐ the person's community treatment order should be cancelled and the person should be released without being subject to a community treatment order (*also complete Form 22*),

OR

☐ the person's community order should be continued and amendments to it are not necessary,

OR

☐ the person's community treatment order should be continued but amendments to it are necessary (*also complete Form 21*)

OR

☐ the person's community treatment order should be cancelled and admission certificates issued in accordance with sections 2 and 6 of the *Mental Health Act* (*also complete Form 1*).

(signature of psychiatrist, physician or designated physician) (date and time)

Form 25

Community Treatment Order

Designation of Physician

Mental Health Act

Section 9.7

I, (name of person authorized by board or regional health authority to make this designation) of (name of regional health authority), pursuant to section 9.7 of the *Mental Health Act*, designate the following physician to act in the place of a psychiatrist for the purpose of issuing, renewing, amending or cancelling a community treatment order or issuing an apprehension order when no psychiatrist is available to carry out those functions:

(name of designated physician)

(signature of person authorized by board or regional health authority)

(date)

I acknowledge this designation and the requirement to consult with a psychiatrist prior to exercising this authority.

(signature of designated physician)

Form 26

Community Treatment Order

Written Statement

Mental Health Act

Section 14(1.1)(a)

TO:
(Name of person) _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

☐ You are now subject to a community treatment order *(attach Form 19)* pursuant to section 9.1 of the *Mental Health Act*. The reason for issuance of the community treatment order is: _____
_____.

☐ The attached community treatment order has been renewed *(attach Form 20)* pursuant to section 9.3 of the *Mental Health Act*. The reason for the renewal of the community treatment order is:
_____.

☐ Your community treatment order has been amended *(attach Form 21)* pursuant to section 9.4 of the *Mental Health Act*. The reason for the amendment of the community treatment order is:
_____

_____ _____
(signature of issuing psychiatrist) (date)

_____
(phone number)

Important Information:

You have a right to apply to a review panel for cancellation of this community treatment order.

You may apply for cancellation of this community treatment order by filing an application with the chair of your review panel. An application may be filed by you, your agent, your guardian or another person on your behalf.

Name of chair of appropriate review panel

Address of appropriate review panel

Form 27

Community Treatment Order

Non-compliance Report

Mental Health Act

Section 9.1(2)(f)

Name of person: _____
Address (if known): _____
Phone (if known): _____
Date of Birth: _____ Personal Health Care Number: _____

The person who is subject to this community treatment order has failed to comply with the following requirements of the treatment or care plan on the dates specified:

Date: _____ Treatment or Care: _____
Date: _____ Treatment or Care: _____

_____ _____
(signature of treatment or care provider) (date)

_____
(print name of treatment or care provider)

_____
(phone number)

Reporting obligations
In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

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