INPATIENT TREATMENT ORDER – LEVEL 1 –

(MRMHA-B)

1a. Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Mental Health Act 2009 – Sections 21, 22, 23

1b. PERSON ADDRESS DETAILS *(if not on or different from patient label above)*

Address: .....

Suburb/town: ..... Postcode: ___ ___ ___ ___

2. EXAMINATION OF PERSON

I have examined the above named person on:

__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)

Location of examination: .....

Please specify: emergency dept, ward and hospital, community mental health site, GP clinic or residence.

3. INPATIENT TREATMENT ORDER

I have examined the above named person, and it appears that all the following criteria for making the **Level 1 Inpatient Treatment Order** are fulfilled:

1. The person has a mental illness; **and**
2. Because of the mental illness, the person requires treatment for their own protection from mental or physical harm (including harm involved in the continuation or deterioration of their condition) or for the protection of others from harm; **and**
3. The person has impaired decision-making capacity relating to the treatment of their mental illness, **and**
4. There is no less restrictive means than an Inpatient Treatment Order of ensuring appropriate treatment of the person's illness.

NOTE: *Consideration must be given , amongst other things, as to whether the person could receive all treatment of the illness necessary for the protection of the person and others on a voluntary basis or in compliance with a Community Treatment Order.*

I therefore order that the person be involuntarily treated in an approved treatment centre or limited treatment centre.

This order expires: __ __ /__ __ / 20 __ __ at 14:00 (24-hour clock)

*(Expiry must be 14:00 on a business day not later than **7 days** after the day on which it was made, unless varied or revoked)*

The person must be informed that they are subject to an order as soon as clinically indicated.

NOTE: *The health professional making the order MUST arrange for examination by a psychiatrist or authorised medical practitioner to occur within 24 hours or as soon as practicable thereafter.*

4. HEALTH PROFESSIONAL MAKING ORDER

Full Name *(Please print):*	Psychiatrist ☐ Authorised Mental Health Professional ☐ Medical Practitioner ☐ Authorised Medical Practitioner ☐
Signature	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print):*	

TURN OVER FOR – ADMISSION OF INVOLUNTARY INPATIENT FROM INTERSTATE

Office of the Chief Psychiatrist	Inquiries: (08) 8226 1091	Act Forms Fax: (08) 8115 5551
Internet: www.chiefpsychiatrist.sa.gov.au		Act Forms Email: HealthOCPMHLO@sa.gov.au

SA Health

Created May 2017

Sensitive: Medical *(When completed)* - I2 - A2

Please turn over—continued over the page

Please use black ballpoint pen when completing this form

INPATIENT TREATMENT ORDER – LEVEL 1 –

(MRMHA-B)

1a Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

5. TRANSFER OF AN INVOLUNTARY INPATIENT FROM INTERSTATE

The above named person is subject to an interstate inpatient treatment order and has been transferred to South Australia under section 71(3) using **form MRMHA-T**.

Section 71(3) provides that a person will be subject to a level 1 inpatient treatment order from the time of admission to the South Australian treatment centre.

This order expires: __ __ /__ __ / 20 __ __ at 14:00 (24-hour clock)

(Expiry must be at 14:00 on a business day not later than 7 days after the day on which the person was admitted to the South Australian treatment centre, unless varied or revoked).

The person must be informed that they are subject to an order as soon as clinically indicated.

*(**NOTE:** The health professional making the order MUST arrange for examination by a psychiatrist or authorised medical practitioner to occur within 24 hours or as soon as practicable thereafter).*

6. MEDICAL PRACTITIONER ADMITTING PATIENT AND MAKING ORDER

Full Name *(Please print):*	Psychiatrist ☐ Authorised Medical Practitioner ☐ Medical Practitioner ☐
Signature	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print):*	

7. HEALTH SERVICE / AGENCY OBLIGATIONS

The person must be given a copy of this form as soon as practicable.
The person must be given a copy of Statement of Rights #4 as soon as practicable.
The guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of this form (if appropriate) as soon as practicable.
The guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of statement of rights #4 (if appropriate) as soon as practicable.
The Chief Psychiatrist must be sent a copy of page 1 of this form (unless it's an interstate matter) within 1 business day.
The reasons for the making of this order, the provision of copies and making of notifications must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.