STATEMENT OF REASONS
(level 1 treatment order) and
REPORT TO DIRECTOR
(level 2 inpatient treatment order)

(MRMHA-E)

1a. Affix patient identification label in this box

Hospital: ....

UR No: ....

Surname: ....

Given Name: ....

Second Given Name: ....

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

South Australian Civil and Administrative Tribunal Act 2013 – Subsection 35(2)
Mental Health Act 2009 – Subsection 26(4)

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

Address: ....

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

2. STATEMENT OF REASONS / REPORT TO DIRECTOR

Subsection 35(2) of the *SACAT Act 2013* and subsection 26(4) of the *Mental Health Act 2009* require the psychiatrist or authorised medical practitioner who is confirming a level 1 community treatment order or level 1 inpatient treatment order, or making or extending a level 2 inpatient treatment order, to provide a written statement of reasons or report to the Director of the treatment centre for the decision.

The statement of reasons / report to the Director must summarise the evidence used by the psychiatrist or authorised medical practitioner to determine that the above named person meets the criteria for a treatment order.

This form is mandatory. Additional casenote entry justifying the order is not required.

I hereby provide a statement of reasons / report to the Director for the

☐ Confirmation of the level 1 community treatment order, or

☐ Confirmation of the level 1 inpatient treatment order, or

☐ Making or extension of a level 2 inpatient treatment order,

That I completed on __ __ /__ __ / 20 __ __ .

Criterion 1: mental illness *(actions, appearance, behaviour, beliefs, history, mood, speech, thoughts)*

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....

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....

Criterion 2: risk of harm *(harm to mental or physical health from continuation or deterioration of condition, harm to self, harm to others)*

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Criterion 3: impaired decision making capacity *(inability to understand, retain, use or communicate information relating to treatment of the mental illness)*

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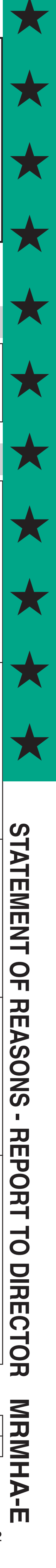

Office of the Chief Psychiatrist	Inquiries: (08) 8226 1091	Act Forms Fax: (08) 8115 5551
Internet: www.chiefpsychiatrist.sa.gov.au	Act Forms Email: HealthOCPMHLO@sa.gov.au	

SA Health

Created May 2017

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

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Please use black ballpoint pen when completing this form

STATEMENT OF REASONS (level 1 treatment order) and **REPORT TO DIRECTOR** (level 2 inpatient treatment order) (MRMHA-E)	**1a.** Affix patient identification label in this box Hospital: ... UR No: ... Surname: ... Given Name: ... Second Given Name: ... D.O.B: ... Sex: ...

2. STATEMENT OF REASONS / REPORT TO DIRECTOR *(continued)*

Criterion 4: no less restrictive means *(to provide effective treatment for the mental illness)*

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...

...

Other supporting information *(other evidence, information, reports)*

...

...

...

...

Provisional diagnosis: ...

...

...

Treatment justification *(explain why treatment for the mental illness is required)*

...

...

...

...

How conclusion reached *(explain, given the evidence above, how you made your determination)*

...

...

...

...

Reason for any delay in confirmation of a level 1 treatment order *(if the order was not confirmed within 24 hours)*

...

...

3. PSYCHIATRIST OR AUTHORISED MEDICAL PRACTITIONER

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

4. HEALTH SERVICE / AGENCY OBLIGATIONS

On confirmation of a level 1 treatment order this form must be completed and placed in the medical record.
On making or extending a level 2 inpatient treatment order this form must be completed and sent to the Director of the treatment centre.
The Chief Psychiatrist must be sent a copy of this form when used as a report to the director.