PATIENT TRANSPORT REQUEST

(MRMHA-I)

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—Section 55

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

Address: ....

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

2. PATIENT TRANSPORT REQUEST

This **Patient Transport Request** is issued for the above named person who meets 1 or more of the following criteria in accordance with *s55(1)* of the Act:

	Tick if applicable
A Community Treatment Order applies to the person and the person has not complied with the requirements of the order; (Under *s55(1)(a)* a medical practitioner or mental health clinician may issue a request meeting this criterion)	☐
A Level 1 Inpatient Treatment Order has been made for the above named person and transport to a treatment centre is required; (Under *s55 (1)(b)* a medical practitioner or authorised mental health professional may issue a request meeting this criterion)	☐
The above named person is absent without leave and requires transport to a treatment centre; (Under *s55(1)(c)* a director of a treatment centre, a medical practitioner or mental health clinician may issue a request meeting this criterion)	☐
An Inpatient Treatment Order applies to the above named person and transportation is required to another treatment centre or hospital. (Under *s55(1)(d), s35(1),(2)* the Director of the treatment centre may issue a request meeting this criterion)	☐
Transport is required to carry out an action to or from another State or Territory. (Under *Part 10* - Arrangements between South Australia and other jurisdictions)	☐

I hereby request the above named person be taken into the care and control of an authorised officer or police officer with the powers conferred to them under *s56, s57, s58 and s59* of the Act to be transported from:

....

to:

.... (print name of treatment centre/hospital/community facility)

3. HEALTH PROFESSIONAL MAKING REQUEST

Full Name *(Please print)*:	Medical Practitioner ☐ AMP / Psychiatrist ☐ Director of Treatment Centre ☐ Mental Health Clinician ☐
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Work address *(Please print)*:	

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

PATIENT TRANSPORT REQUEST

MRMHA-I

PATIENT TRANSPORT REQUEST (MRMHA-I)	**1a.** Affix patient identification label in this box Hospital: .... UR No: .... Surname: .... Given Name: .... Second Given Name: .... D.O.B: .... Sex: ....

4. 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 #2 as soon as practicable.
A guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of this form (if appropriate), as soon as practicable.
A guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of statement of rights #2 (if appropriate), as soon as practicable.
The reasons for the making of this request and the provision of copies must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

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