

**TRANSFER OF AN INVOLUNTARY
INPATIENT BETWEEN TREATMENT
CENTRES/HOSPITALS IN SA
(MRMHA-K)**

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 35

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

Address:
 Suburb/town: Postcode: ____ _

2. TRANSFER BETWEEN TREATMENT CENTRES

I hereby direct the transfer of the above named person, to whom an Inpatient Treatment Order applies as per s35(1) of the Act from
 (print name of treatment centre)
 to
 (print name of treatment centre)
 The treatment centre must, in the case of a patient to whom a level 2 or level 3 Inpatient Treatment Order applies, be an approved treatment centre (not a limited treatment centre).

OR

3. TRANSFER BETWEEN TREATMENT CENTRE and HOSPITAL or between HOSPITALS
(for use in circumstances where the person has or has had an illness other than a mental illness)

I hereby direct the transfer of the above named person, to whom an Inpatient Treatment Order applies as per s35(2) of the Act from
 (Treatment centre/hospital)
 to
 (Treatment centre/hospital)
 s35(2)(a) allows for the transfer to a hospital, or between hospitals
 s35(2)(b) allows for the return of the patient to the treatment centre on completion of the hospital treatment

4. DIRECTOR OF TREATMENT CENTRE (or delegate) AUTHORISING TRANSFER

Full Name <i>(Please print):</i>	Director <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Authorised medical practitioner <input type="checkbox"/> Delegate <i>(post consultation with director, psychiatrist or AMP)</i> <input type="checkbox"/>
Signature	___ / ___ / 20 ___ at ___ : ___ (24-hour clock)
Work address <i>(Please print):</i>	

5. HEALTH SERVICE / AGENCY OBLIGATIONS

The person must be given a copy of this form 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 reasons for the making of this transfer and the provision of copies must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

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	