APPLICATION FOR NEUROSURGERY FOR MENTAL ILLNESS

(MRMHA-N)

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 43

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

Address: .....

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

2. DOCUMENTS REQUIRED FOR THIS APPLICATION

☐ Consent by the person or, if not capable of providing consent, by SACAT.

☐ Report from the treating neurosurgeon.

☐ Report from the treating psychiatrist.

☐ Report from a second psychiatrist who has examined the patient.

This application and the four attachments must be provided to the Chief Psychiatrist at least 14 days before the neurosurgery is proposed to be carried out.

3. NEUROSURGEON AUTHORISATION

I am satisfied that the person has a mental illness and that neurosurgery is the most appropriate treatment for the mental illness.

Full Name *(Please print):*	Designation *(Please print):*
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print):*	

4. TREATING PSYCHIATRIST AUTHORISATION

I am satisfied that the person has a mental illness and that neurosurgery is the most appropriate treatment for the mental illness.

Full Name *(Please print):*	Designation *(Please print):*
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print):*	

5. SECOND PSYCHIATRIST (SENIOR) AUTHORISATION

I am satisfied that the person has a mental illness and that neurosurgery is the most appropriate treatment for the mental illness.

Full Name *(Please print):*	Designation *(Please print):*
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(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

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(MRMHA-N)

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UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

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

6. AUTHORISATION BY PERSON

The following aspects of neurosurgery for mental illness have been explained clearly and fully to me:

- ☐ Why the surgery is needed.
- ☐ What the surgery will involve.
- ☐ Any consequences and risks of the surgery.
- ☐ Any alternative treatments or options that may be available.
- ☐ I consent to neurosurgery for mental illness.

Full Name *(Please print):*	
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)

7. PRESCRIBED PSYCHIATRIC TREATMENT PANEL DETERMINATION

This application for neurosurgery for mental illness was consided by the Prescribed Psychiatric Treatment Panel on:

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

The Prescribed Psychiatric Treatment Panel:

- ☐ **authorises** the use of neurosurgery for mental illness, or
- ☐ **does not authorise** the use of neurosurgery for mental illness.

See the attached report of the Prescribed Psychiatric Treatment Panel for details.

8. CHIEF PSYCHIATRIST VERIFICATION OF AUTHORISATION

I hereby verify that the Prescribed Psychiatric Treatment Panel report attached is a fair and accurate record of the deliberations and decisions of the Panel.

Full Name *(Please print):*	Chief Psychiatrist
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)

9. HEALTH SERVICE / AGENCY OBLIGATIONS

The person must be given a copy of this form 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.

The Chief Psychiatrist must be sent a copy of pages 1 and 2 of this form, and the four attachments, at least 14 days before the neurosurgery is proposed to be carried out.

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