INTERSTATE REQUEST

(MRMHA-R)

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 74(1) and 75(2)

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

Address: .....

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

2. TRANSPORT OF A PERSON WHO APPEARS TO HAVE A MENTAL ILLNESS FROM SOUTH AUSTRALIA TO ANOTHER STATE

I have taken the above named person into my care and control because they appear to have a mental illness and require a medical examination. I am requesting approval to transport the person:

☐ Into the care and control of an interstate officer, or

☐ To an interstate treatment centre, interstate medical practitioner or interstate authorised mental health professional.

Section 63 – This power may only be used if it's in the best interests of the patient.

OR

3. TRANSPORT OF A PERSON NEWLY SUBJECT TO A SOUTH AUSTRALIAN INPATIENT TREATMENT ORDER TO ANOTHER STATE

The above named person has been made subject to a South Australian inpatient treatment order and rather than transporting the person to a South Australian treatment centre I am requesting approval to transport the person:

☐ Into the care and control of an interstate officer for transport to an interstate treatment centre, or

☐ To an interstate treatment centre.

Document required with this request:

☐ Copy of approval from the interstate treatment centre or officer for the transport.

Section 63 – This power may only be used if it's in the best interests of the patient.

4. HEALTH PROFESSIONAL MAKING REQUEST

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

5. CHIEF PSYCHIATRIST APPROVAL

I hereby authorise the transport of the above named person as described above.

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

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

INTERSTATE REQUEST MRMHA-R

INTERSTATE REQUEST

(MRMHA-R)

1a. Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

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

6. 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 or #4 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 or #4 (if appropriate), as soon as practicable.
The Chief Psychiatrist must be notified when the transport is carried out.
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.