TREATMENT IN SOUTH AUSTRALIA UNDER AN INTERSTATE ORDER

(MRMHA-S)

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 68(2) and 76(1)

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

Address: ....

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

2. TREATMENT IN SOUTH AUSTRALIA FOR A PERSON SUBJECT TO AN INTERSTATE COMMUNITY TREATMENT ORDER

The above named person is subject to an interstate community treatment order.

☐ I am seeking approval to provide treatment in South Australia under an interstate community treatment order. I am aware that treatment can only be provided in this way for up to a maximum of 42 days (or less if the interstate order expires earlier).

Documents required with this request:

☐ Copy of the interstate community treatment order.

☐ Copy of interstate clinical and/or discharge documents.

OR

3. TREATMENT IN SOUTH AUSTRALIA FOR A PERSON SUBJECT TO AN INTERSTATE INPATIENT TREATMENT ORDER

The above named person is subject to an interstate inpatient treatment order.

☐ I am seeking approval to provide treatment in a South Australian treatment centre under the interstate inpatient treatment order pending the person's transport to an interstate treatment centre.

Documents required with this request:

☐ Copy of the interstate inpatient treatment order.

☐ Copy of interstate clinical and/or discharge documents.

4. HEALTH PROFESSIONAL MAKING REQUEST

Full Name *(Please print)*:	Director ☐ Psychiatrist ☐ Medical Practitioner ☐ Delegate *(post consultation with director, psychiatrist or AMP* ☐
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print)*:	

5. CHIEF PSYCHIATRIST APPROVAL

I hereby authorise the treatment of the above named person in South Australia.

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

Please turn over—continued over the page

Please use black ballpoint pen when completing this form

TREATMENT IN SOUTH AUSTRALIA UNDER AN INTERSTATE ORDER (MRMHA-S)	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 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 person must be given a copy of Statement of Rights #3 or #4 as soon as practicable.
The guardian, substitute decision maker (medical agent), relative, carer or friend of the patient must be given a copy of Statement of Rights #3 or #4 (if appropriate) as soon as practicable.
The Chief Psychiatrist must be notified when treatment is commenced in South Australia for a person subject to an interstate treatment order.
The reasons for the making of this treatment request, the provision of copies and making of notifications must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

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