Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

CONSENT FORM – *Northwest Territories Mental Health Act*

COMMUNITY TREATMENT PLAN – PATIENT CONSENT

* The attending medical practitioner **must** have a signed *Community Treatment Plan – Patient Consent* before contacting a provider or monitor to perform supervision, treatment, care, and/or support under a *Community Treatment Plan*.

Name of Patient			Gender		
Health Care Number			Date of Birth (DD-MM-YYYY)		
Address of Patient					
Street	Community	Postal Code			
Designated Facility (where admitted)					
Name					
Street	Community	Postal Code			
Attending Medical Practitioner Preparing *Community Treatment Plan*					
Name					
Street	Community	Postal Code			
Email Address	Contact Number				
If Different, Medical Practitioner Responsible for General Supervision and Management of *Community Treatment Plan* (Supervising Medical Practitioner)					
Name					
Street	Community	Postal Code			
Email Address	Contact Number				

Current Involuntary Admission Certificate	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Name of Attending Medical Practitioner who Issued Certificate**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
Certificate of Involuntary Admission					
OR *Renewal Certificate*					

PATIENT AGREEMENT

Patient or Substitute Decision Maker Initial	
	I understand that I am being considered for participation in a *Community Treatment Plan*, which may result in my ability to live in the community while undergoing treatment, but only on the terms set out in the *Community Treatment Plan*. I must agree to take part in the *Community Treatment Plan*.
	The *Community Treatment Plan* may require me to attend appointments with my medical practitioner for assessments at the dates, times, and locations agreed to.
	The *Community Treatment Plan* may require me, while living in the community, to meet with persons who will provide me with supervision, treatment, care, and/or support and who will report my progress to the Supervising Medical Practitioner. I consent to my personal and/or personal health information being shared with those persons to determine whether they can participate in my *Community Treatment Plan* and during the course of my *Community Treatment Plan*, if approved.
	The *Community Treatment Plan* may require me to be monitored while living in the community by persons (such as my substitute decision maker, family members, or other persons) who will assist me with my compliance with the *Community Treatment Plan*, monitor my progress and report to the Supervising Medical Practitioner. I consent to my personal and/or personal health information being shared with those persons to determine whether they can participate in my *Community Treatment Plan* and during the course of my *Community Treatment Plan*, if approved.
	I understand that I can withdraw the consent I am providing to disclose my personal and/or personal health information at any time.
	I understand that there is no guarantee by signing this *Community Treatment Plan – Patient Consent* that I will be approved for a *Community Treatment Plan*.

Restrictions on the above consents to disclose personal and/or personal health information are to be noted here (if any):

I, _____, consent to my personal and/or personal health information being shared as provided for in this *Community Treatment Plan – Patient Consent* in order to determine whether my circumstances are suitable for participation in a *Community Treatment Plan* and during the course of my *Community Treatment Plan*, if approved.

_____ X _____

Printed Name of Patient or Substitute Decision Maker | Signature

Dated this _____ day of _____, 20 _____ at _____ .
(Time)

Attending Medical Practitioner

_____ X _____ PLEASE PRINT FORM TO SIGN

Printed Name of Attending Medical Practitioner | Signature

Dated this _____ day of _____, 20 _____ at _____ .
(Time)

The personal health information on this form is being collected under the authority of the *Mental Health Act*. It is protected by the privacy provisions under the *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about this form, please contact the Clinical Mental Health Program Specialist at 867-767-9061 or mhact_reviewboard@gov.nt.ca