Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

**FORM 11 – *Northwest Territories Mental Health Act***

# TREATMENT DECISION CERTIFICATE

This certificate specifies that the patient has been assessed by a medical practitioner and it has been determined the patient is not capable of making their own treatment decisions.

| Name of Patient | | Gender |
|---|---|---|
| Health Care Number | | Date of Birth (DD-MM-YYYY) |
| **Address of Patient** | | |
| Street | Community | Postal Code |
| **Patient Status under the *Mental Health Act*** | | |
| ☐ Voluntary Patient ☐ Involuntary Patient ☐ Other Specify: _____ | | |
| **Designated Facility** (where admitted) | | |
| Name | | |
| Street | Community | Postal Code |
| Date of admission to designated facility (DD-MM-YYYY) | Date of assessment of mental competence (DD-MM-YYYY) | Time of assessment of mental competence |

## TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING CERTIFICATE

I, _____, of _____,
(Attending Medical Practitioner) (Address)

have performed an assessment of mental competence to make treatment decisions, and am of the opinion that

_____, is **not** mentally competent to make their own treatment decisions.
(Full Name of Patient)

**In determining the mental competence of the patient, I have considered (please check):**

Whether the patient understands:

- ☐ the conditions for which treatment is proposed,
- ☐ the nature and purpose of the treatment,
- ☐ the risks and benefits involved in undergoing treatment, and
- ☐ the risks and benefits of not undergoing treatment.

**AND**

- ☐ Whether the mental condition affects the patient's ability to appreciate the consequences of making treatment decisions.

**The following information supports my opinion:**

State specific indications that the patient is not mentally competent to make treatment decisions:

| | |
|---|---|
| Dated this _____ day of _____, 20 _____ at _____ . (Time) | |
| _____ Printed Name of Attending Medical Practitioner | X PLEASE PRINT FORM TO SIGN _____ Signature |

**Distribution Note:**

- This form must be filed with the director of the designated facility where the patient is admitted involuntarily.
- Copies need to be provided to the patient, and if applicable:
  (a) Substitute decision maker
  (b) Person designated by patient to receive information
  (c) A person with lawful custody or authority if the patient is a minor
  (d) Legal guardian
  (e) Agent under a personal directive
  (f) Relative (with patient's consent if (a) to (e) do not apply)

**Additional Actions Required:**

- Seek out a substitute decision maker to represent the patient and complete the *Designation of Substitute Decision Maker* form.

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