



**FORM 13 – Northwest Territories Mental Health Act**

**CANCELLATION OF TREATMENT DECISION CERTIFICATE**

This certificate indicates that the patient has been assessed by a medical practitioner, and it has been determined the patient is now capable of making their own treatment decisions. The *Treatment Decision Certificate* and *Designation of Substitute Decision Maker* form are no longer in effect.

Name of Patient		Gender
Health Care Number		Date of Birth (DD-MM-YYYY)
<b>Address of Patient</b>		
Street		Community
Postal Code		
<b>Patient Status Under the Mental Health Act</b>		
<input type="checkbox"/> Voluntary Patient <input type="checkbox"/> Involuntary Patient <input type="checkbox"/> Other Specify: _____		
<b>Designated Facility (where admitted)</b>		
Name		
Street		Community
Postal Code		
<b>Treatment Decision Certificate being Cancelled</b>		
Date of Issue (DD-MM-YYYY)	Time of Issue	Attending Medical Practitioner who issued certificate
<b>Date and Time of Current Assessment of Mental Competence</b>		
Date of Assessment (DD-MM-YYYY)		Time of Assessment

**TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING THE CANCELLATION**

I \_\_\_\_\_, of \_\_\_\_\_,  
(Attending Medical Practitioner) (Address)

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

\_\_\_\_\_, IS mentally competent to make their own treatment decisions.  
(Full Name of Patient)

**The following information supports my opinion:**

State specific indications that the patient is mentally competent to make treatment decisions:

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_ at \_\_\_\_\_.  
(Time)

Printed Name of Attending Medical Practitioner

 Signature

**Distribution Note:**

- This form must be filed with the director of the designated facility where the patient was admitted involuntarily.

**Additional Actions Required:**

- Notice of cancellation needs to be provided to:
  - (a) the patient
  - (b) all other persons provided with a copy of the *Treatment Decision Certificate*

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](mailto:mhact_reviewboard@gov.nt.ca)

If you would like this information in another official language, contact us at 1-855-846-9601. / Si vous voulez ces informations dans une autre langue officielle, téléphonez-nous au 1-855-846-9601.