Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 16 – *Northwest Territories Mental Health Act*

SHORT TERM LEAVE CERTIFICATE

The purpose of this certificate is to provide short term leave to involuntary patients for up to a maximum of 30 days. The person named in the certificate remains an involuntary patient of the designated facility while on short term leave.

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
Certificate of Involuntary Admission* or *Renewal Certificate		
Date of Issue (DD-MM-YYYY)	Time of Issue	Medical Practitioner who issued certificate
Date of Expiry (DD-MM-YYYY)	Time of Expiry	

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING CERTIFICATE

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

issue this *Short Term Leave Certificate* for _____, on _____ at _____ .
(Full Name of Patient) Date (DD-MM-YYYY) (Time)

While on short term leave, _____ remains an involuntary patient.
(Full Name of Patient)

This *Short Term Leave Certificate* expires on _____ **at** _____ **.**
Date (DD-MM-YYYY) (Time)

This *Short Term Leave Certificate* will be cancelled if:

- the medical practitioner is of the opinion that the patient's mental condition may result in harm to the patient or another person;
- the patient has failed to comply with one or more conditions of the Certificate; or
- the *Certificate of Involuntary Admission* or *Renewal Certificate* by which the patient's involuntary status was established expires

_____ .
Date (DD-MM-YYYY)

The Patient on this *Short Term Leave Certificate* is subject to the following conditions:

For example: the patient must report for monitoring/appointments/treatment (time, frequency, location)

_____ **must return to** _____
(Patient Name) (Facility)

by _____ **at** _____ **unless he/she ceases to be an involuntary patient before that time.**
Date (DD-MM-YYYY) (Time)

PATIENT AND SUBSTITUTE DECISION MAKER AGREEMENTS

To be completed by patient:

Patient Initial	**I understand that:**
	I remain an involuntary patient of the facility, even though I am on short term leave. The *Certificate of Involuntary Admission* or *Renewal Certificate* under the *Mental Health Act* remains in effect.
	I can voluntarily return to the designated facility prior to the expiration of the short term leave.
	I am *required* to return to the facility by the date and time specified above, unless I cease to be an involuntary patient prior to that date.
	This certificate may be cancelled if the medical practitioner believes my mental condition may result in harm to myself or others if I do not return to the designated facility.
	This certificate may be cancelled if I fail to comply with any of the conditions outlined above.
	If this certificate is cancelled, it means that I must immediately return to the designated facility after receiving notice of its cancellation, unless I cease to be an involuntary patient before that time.
	If I fail to return to the designated facility as required, I may be apprehended by a peace officer and returned to the designated facility.

To be completed by patient and substitute decision maker (if applicable)**:**

I, _____, agree to comply with the conditions outlined in this certificate to the best of my abilities.
(Name of Patient)

I, _____, consent to the issuance of this *Short Term Leave Certificate*.
(Name of Patient or Substitute Decision Maker)

Printed Name of Patient	X Signature	Date (DD-MM-YYYY)	(Time)
Printed Name of Substitute Decision Maker (if applicable)	X Signature	Date (DD-MM-YYYY)	(Time)

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER WHO ISSUES CERTIFICATE

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)

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 Informat on 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