Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 17 – *Northwest Territories Mental Health Act*

CANCELLATION OF SHORT TERM LEAVE CERTIFICATE

The purpose of this form is to cancel the *Short Term Leave Certificate*. The involuntary patient must return to the designated facility as soon as possible.

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	Attending Medical Practitioner who issued certificate	
Date of Expiry (DD-MM-YYYY)	Time of Expiry		
***Short Term Leave Certificate* being Cancelled**			
Date of Issue (DD-MM-YYYY)	Time of Issue	Attending Medical Practitioner who issued certificate	
Date of Expiry (DD-MM-YYYY)	Time of Expiry		

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING THE CANCELLATION

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

issue this *Cancellation of Short Term Leave Certificate* for _____
(Full Name of Patient)

on _____ at _____ .
Date (DD-MM-YYYY) (Time)

The *Cancellation of Short Term Leave Certificate* is based on the following (please check):

☐ The patient's mental condition may result in harm to the patient or another person if the patient does not return to the designated facility.

OR

☐ The patient has failed to comply with one or more of the conditions of the Certificate.

The following information supports my opinion:

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

PLEASE PRINT FORM TO SIGN

Printed Name of Attending Medical Practitioner

X _____
Signature

Distribution Note:

- This form must be filed with the director of the designated facility where the patient is 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 *Short Term Leave Certificate*
- If patient does not return to the designated facility, the attending medical practitioner or director of the designated facility must issue an *Unauthorized Absence Statement* to have the patient apprehended by a peace officer and returned to the facility.

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