Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 18 – *Northwest Territories Mental Health Act*

UNAUTHORIZED ABSENCE STATEMENT

This statement authorizes a peace officer to take the involuntary patient into custody immediately and return the patient to the designated facility. This authority is valid for up to **30 days** from date of issue.

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

Current Certificates	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Medical Practitioner who Issued Certificate**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
☐ *Certificate of Involuntary Admission* or *Renewal Certificate*					
☐ *Short Term Leave Certificate* (if applicable)					
☐ *Assisted Community Treatment Certificate* (if applicable)					

The patient is absent without authorization, under the following conditions:

☐ The patient is absent from the designated facility without authority under a *Short Term Leave Certificate* or an *Assisted Community Treatment Certificate*;

☐ The patient was absent under the authority of a *Short Term Leave Certificate* that has expired or been cancelled and they have not returned to the designated facility; or

☐ The patient was absent under the authority of an *Assisted Community Treatment Certificate* that has expired or been cancelled and they have not returned to the designated facility.

I _____, of _____,
(Director of the Designated Facility/Attending Medical Practitioner) (Address)

authorize that the involuntary patient named in this form be taken into custody and returned to

_____, at _____.
(Name of Designated Facility) (Address)

Name of Patient		
Last known home address of patient		
Street	Community	Postal Code
Description of patient		
Other pertinent information related to possible whereabouts of patient (including last known location)**:**		

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

_____ X PLEASE PRINT FORM TO SIGN _____

Printed Name of Director of Designated Facility/Attending Medical Practitioner | Signature

Additional Actions Required:

- A *Summary Statement Respecting Apprehension or Conveyance* may be required by the peace officer or other authorized person responsible for apprehension and/or conveyance.

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