Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

FORM 20 – *Northwest Territories Mental Health Act*

NOTICE TO REVIEW BOARD

This form is to provide notice to the Northwest Territories Mental Health Act Review Board to hold a mandatory hearing.

This form must be completed by the director of the designated facility where the involuntary patient is admitted a minimum of 14 days prior to the patient reaching 6 months of continuous involuntary admission status without a previous application for an order cancelling the certificates.

DIRECTOR'S STATEMENT

______________________ has been an involuntarily patient at ______________________
(Patient Name) (Designated Facility)

since ______________ .
(DD-MM-YYYY)

The above-named person will have been an involuntary patient under the *Mental Health Act* for a continuous period of 6 months on

______________, without review by a Review Panel. On this date, section 68 of the *Mental Health Act* will be triggered,
(DD-MM-YYYY)

requiring a review of the patient's *Certificate of Involuntary Admission* and/or *Renewal Certificate*.

The above-named patient has been under the following continuous certificates and renewals of involuntary admission:

	Date Certificate Issued (DD-MM-YYYY)	Date Certificate Expired/Expires (DD-MM-YYYY)
Certificate of Involuntary Admission		
First Renewal (30 days)		
Second Renewal (60 days)		
Third Renewal (90 days)		
Subsequent Renewal (90 days)		
Subsequent Renewal (90 days)		

PATIENT INFORMATION

Patient Name		
Designated Facility (where admitted)		
Name		
Street	Community	Postal Code
Patient Address Where Residing (if not the designated facility)		
Street	Community	Postal Code

FACILITY INFORMATION

	Name	**Contact**	
Director of designated facility issuing notice		Phone Number	Email
Attending medical practitioner		Phone Number	Email

If the patient is residing outside of the designated facility under an *Assisted Community Treatment Certificate*, please name the health professional or other persons/bodies who have agreed to provide supervision, treatment, care, or other support under the *Community Treatment Plan*:

	Name	Contact Information
Medical practitioner responsible for Plan		
Person/body involved in Plan		
Person/body involved in Plan		
Person/body involved in Plan		
Person/body involved in Plan		

** Attach additional page if more space is required.*

If applicable, please provide the names and contact information (if known) for the person(s) who provide support to the patient:

	Name	Contact Information
Substitute Decision Maker		
Lawyer		
Translator/ Interpreter		
Cultural Advisor/ Elder		
Other Support Person (please specify): ____________		
Other Support Person (please specify): ____________		

** Attach additional page if more space is required.*

____________________________ X ____________________________

Printed Name of Director of Designated Facility | Signature

Dated this ________ day of ____________________, 20 ______ at ______________ .
(Time)

Please fax or email this notice to:

Mental Health Act Review Board
5015-49th St., NGB-6th Floor
Box 1320
Yellowknife NT X1A 2L9
Phone: 867-767-9061 ext. 49177
Fax: 867-873-0143
Email: MHAct_ReviewBoard@gov.nt.ca

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

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.