Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 24 – *Northwest Territories Mental Health Act*

COMMUNITY TREATMENT PLAN REPORT

This report is to be provided to the **Supervising Medical Practitioner** who is responsible for the *Community Treatment Plan*. This report is to provide updates, or information on progress or non-compliance with the *Community Treatment Plan*.

Name of Patient		Gender
Health Care Number		Date of Birth (DD-MM-YYYY)
Address of Patient		
Street	Community	Postal Code

MEDICAL PRACTITIONER SUPERVISING *COMMUNITY TREATMENT PLAN*

Supervising Medical Practitioner's Contact Information		
Name		
Street	Community	Postal Code
Fax Number	Email Address	

Provider Contact Information		
Name		
Street	Community	Postal Code
Fax Number	Email Address	
Role in the *Community Treatment Plan*		

Date (DD-MM-YYYY)	**Treatment, Care, Concerns and/or Progress**

Printed Name of Provider

X PLEASE PRINT FORM TO SIGN
Signature

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

This report is to be sent to the **Supervising Medical Practitioner**.

Date provided to Supervising Medical Practitioner: _____
(DD-MM-YYYY)

By:

- ☐ Fax
- ☐ Email
- ☐ Other: _____

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