FORM 25 – *Northwest Territories Mental Health Act*

ASSISTED COMMUNITY TREATMENT CERTIFICATE, AMENDMENT

The purpose of this document is to amend the *Assisted Community Treatment Certificate* to reflect the transfer of an involuntary patient under the Certificate to a different designated facility within the Northwest Territories.

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

Current Involuntary Admission Certificate	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Name of Attending Medical Practitioner who Issued Certificate**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
Certificate of Involuntary Admission					
OR *Renewal Certificate*					

CERTIFICATE AMENDMENT

***Assisted Community Treatment Certificate* being amended**	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Name of Medical Practitioner who Issued Certificate**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
☐ Original					
☐ 1st Renewal					
☐ 2nd Renewal					
☐ 3rd Renewal					
☐ _____ Renewal (please indicate)					

FACILITY AMENDMENT

Transferring Designated Facility		
Name		
Street	Community	Postal Code
Receiving Designated Facility		
Name		
Street	Community	Postal Code

TO BE COMPLETED BY DIRECTOR OF TRANSFERRING DESIGNATED FACILITY ISSUING THE AMENDMENT

I, _____ of _____,
(Director of Designated Facility) (Transferring Designated Facility)

have authorized the transfer of _____ to _____ .
(Patient Name) (Receiving Designated Facility)

The patient will continue to reside in _____ under the *Assisted Community Treatment*
(Community)

Certificate while admitted as an involuntary patient at the receiving designated facility.

_____ X _____ PLEASE PRINT FORM TO SIGN
Printed Name of Director of Transferring Designated Facility Signature

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

Distribution Note:

- This form, along with the original *Assisted Community Treatment Certificate*, corresponding *Community Treatment Plan*, and **all amendments made**, must be filed with the director of the receiving designated facility.
- Copies need to be provided to all persons provided with the original *Assisted Community Treatment Certificate.*

Additional Actions Required:

- This amendment must be attached to the **original** *Assisted Community Treatment Certificate* and *Community Treatment Plan* and be accompanied by the relevant *Community Treatment Plan Amendment*.
- An *Authorization to Transfer Involuntary Patient to Facility within the Northwest Territories* must be completed to authorize the transfer.
- A *Summary Statement Respecting Apprehension or Conveyance* may be required by the peace officer or other authorized person responsible for 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