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

FORM 26 – *Northwest Territories Mental Health Act*

COMMUNITY TREATMENT PLAN, AMENDMENT

This amendment must be attached to the *Assisted Community Treatment Certificate* and **original** *Community Treatment Plan.*

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

Supervising Medical Practitioner or Director of Designated Facility Responsible for Preparing the *Community Treatment Plan* Amendment		
Name		
Street	Community	Postal Code
Contact Number	Email Address	

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*					
Current *Assisted Community Treatment Certificate* and *Community Treatment Plan*	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Name of Medical Practitioner who Issued Certificate/Plan**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
Assisted Community Treatment Certificate					
Community Treatment Plan					

This amendment is effective on this ________ day of ______________________________, 20 ______ at ______________________ .
(Time)

AMENDMENTS REQUIRED TO THE *COMMUNITY TREATMENT PLAN* (CTP)

Please check the parts of the *Community Treatment Plan* that have amendments, complete the corresponding sections, and attach all relevant sections to the amendment:

- ☐ Supervising Medical Practitioner who is responsible for the *Community Treatment Plan*
- ☐ Designated facility where patient is admitted

Part 1: Treatment Plan

- ☐ A. Required Assessments
- ☐ B. Supervision, Treatment, Care, and/or Support Arrangements
- ☐ C. Monitoring Arrangements
- ☐ D. Additional Terms and Conditions

Part 2: Other Supports

- ☐ A. Housing
- ☐ B. Income
- ☐ C. Other

Agreements to Amendment(s)

I understand the amendments that have been made to the *Community Treatment Plan* for ______________________
(Patient Name)

and agree to participate and comply with the Plan, as amended, to the best of my abilities.

______________________ X ______________________
Printed Name of Patient or Substitute Decision Maker (if applicable) Signature

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

______________________ X ______________________
Printed Name of Supervising Medical Practitioner or Director of Designated Facility Issuing Amendment Signature

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

______________________ X ______________________
Printed Name of Supervising Medical Practitioner (if different) Signature

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

SUPERVISING MEDICAL PRACTITIONER RESPONSIBLE FOR *COMMUNITY TREATMENT PLAN*

Current Supervising Medical Practitioner

Name		Facility
Street	Community	Postal Code
Contact Number		Email Address

New Supervising Medical Practitioner

Name		Facility
Street	Community	Postal Code
Contact Number		Email Address

I, ______________________________ of ______________________________,
(New Supervising Medical Practitioner) (Facility)

will be responsible for the general supervision and management of the *Community Treatment Plan*.

______________________________ X ______________________________
Printed Name of New Supervising Medical Practitioner Signature

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

DESIGNATED FACILITY WHERE PATIENT IS ADMITTED*

Transferring Designated Facility

Name		Facility
Street	Community	Postal Code

Receiving Designated Facility

Name		Facility
Street	Community	Postal Code

* *This document must be accompanied by the relevant* Assisted Community Treatment Certificate Amendment*. The* Assisted Community Treatment Certificate *and corresponding* Community Treatment Plan*, along with all amendments made, must be filed with the director of the receiving designated facility.*

PART 1: TREATMENT PLAN

A. REQUIRED ASSESSMENTS

The patient must attend the following assessments, in addition to the ongoing psychiatric assessments required of an involuntary patient, at the dates, times, and locations as agreed to between the person and the Supervising Medical Practitioner:

- Assessments to examine effectiveness of *Community Treatment Plan* and compliance:
  - Within 30 days from release from designated facility (“First Assessment”)
  - Within 30 days of First Assessment (“Second Assessment”)
  - Within 72 hours before expiry of *Assisted Community Treatment Certificate* or renewal of the Certificate (“Third Assessment”)
  - At reasonable ongoing basis as required by Supervising Medical Practitioner (“Additional Assessment”)
  - At reasonable request of patient, substitute decision maker, or other person/body named in the *Community Treatment Plan* (“Additional Assessment”)
- Psychiatric assessments required for involuntary patients under the *Mental Health Act* (“Psychiatric Assessments”)

Required assessment(s) outlined in the original *Community Treatment Plan* have been rescheduled and ALL future assessments are scheduled as follows:

	Date (DD-MM-YYYY)	Time	Location
First Assessment (<30 days from release)			
Second Assessment (<30 days from First Assessment)			
Third Assessment (72 hours before expiry)			
Additional Assessment(s) (if known)			
Psychiatric Assessments			

B. SUPERVISION, TREATMENT, CARE, AND/OR SUPPORT ARRANGEMENTS **Attach additional page(s) if more space is required.*

The following changes are required to the supervision, treatment, care, and/or support arrangements made under the *Community Treatment Plan* (please indicate below and fill out applicable section(s)):

☐ **i.) Removing Provider(s) from *Community Treatment Plan***

☐ **ii.) Adding Provider(s) to *Community Treatment Plan***

☐ **iii.) Amending Provider(s) role(s) under the *Community Treatment Plan***

i.) Removing Provider(s) from *Community Treatment Plan*

The following persons/bodies will no longer provide supervision, treatment, care, and/or support to the patient under the *Community Treatment Plan*:

Name of Provider	Telephone
Other Contact Information	

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____________

Profession/Role

Description of treatment or care:

Role terminated:	Date (DD-MM-YYYY)	Time

Name of Provider	Telephone
Other Contact Information	

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____________

Profession/Role

Description of treatment or care:

Role terminated:	Date (DD-MM-YYYY)	Time

Name of Provider	Telephone
Other Contact Information	

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____________

Profession/Role

Description of treatment or care:

Role terminated:	Date (DD-MM-YYYY)	Time

I, ______________________________ of ______________________________,
(Supervising Medical Practitioner) (Facility)

have informed the above health professionals, persons, and/or bodies of the termination of their roles and obligations under the *Community Treatment Plan*.

Printed Name of Supervising Medical Practitioner Signature

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

ii.) Adding Provider(s) to *Community Treatment Plan*

The following outlines the additional supervision, treatment, care, and/or support(s) arranged for the patient:

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ____	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

I, ______________________________ of ______________________________,
(Supervising Medical Practitioner) (Facility)

have consulted with and obtained a written agreement from the above health professionals, persons, and/or bodies in respect of the performance of their roles and obligations under this *Community Treatment Plan*. Such agreement includes consent to disclose each health professional, person, and body's name to any other person or body named in the *Community Treatment Plan*.*

______________________________ X ______________________________
Printed Name of Supervising Medical Practitioner Signature

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

** Attach all written agreements to the completed* Community Treatment Plan Amendment.

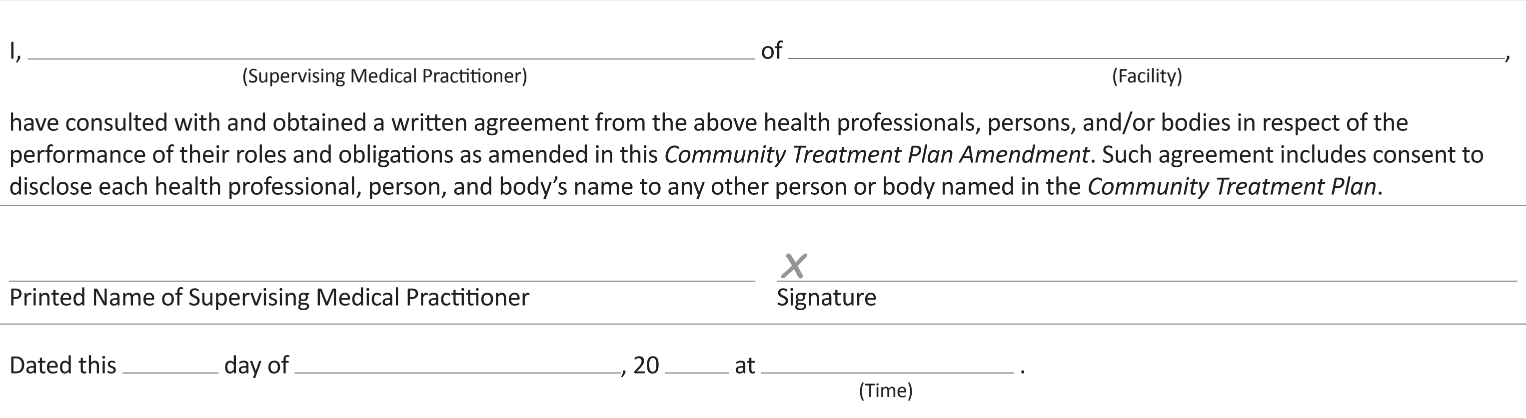
iii.) Amending Provider(s) role(s) under the *Community Treatment Plan*

The following provider(s) supervision, treatment, care, and/or support(s) under the *Community Treatment Plan* are amended by substituting:

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ______	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ______	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): ______	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*



I, ______________________ of ______________________,
(Supervising Medical Practitioner) (Facility)

have consulted with and obtained a written agreement from the above health professionals, persons, and/or bodies in respect of the performance of their roles and obligations as amended in this *Community Treatment Plan Amendment*. Such agreement includes consent to disclose each health professional, person, and body's name to any other person or body named in the *Community Treatment Plan*.

______________________ X ______________________
Printed Name of Supervising Medical Practitioner Signature

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

** Attach all written agreements to the completed* Community Treatment Plan Amendment*.*

C. MONITORING ARRANGEMENTS *Attach additional page if more space is required.*

The following changes are required to the monitoring arrangements made under the *Community Treatment Plan* (please indicate below and fill out applicable section(s)):

☐ **i.) Removing monitoring arrangement(s) from *Community Treatment Plan***

☐ **ii.) Adding monitoring arrangement(s) to *Community Treatment Plan***

☐ **iii.) Amending monitoring arrangement(s) under the *Community Treatment Plan***

i.) Removing Monitoring Arrangement(s) from *Community Treatment Plan*

The following person(s) will no longer provide monitoring support to the patient under the *Community Treatment Plan*:

Name of Monitor		Telephone
Street	Community	Postal Code
Other Contact Information		

☐ Substitute decision maker ☐ Family member (specify): ____________ ☐ Other (specify): ____________

Description of monitoring:

Role terminated:	Date (DD-MM-YYYY)	Time

Name of Monitor		Telephone
Address: Street	Community	Postal Code
Other Contact Information		

☐ Substitute decision maker ☐ Family member (specify): ____________ ☐ Other (specify): ____________

Description of monitoring:

Role terminated:	Date (DD-MM-YYYY)	Time

I, ______________________________ of ______________________________,
(Supervising Medical Practitioner) (Facility)

have informed the above substitute decision maker, family members, or other persons of the termination of their roles and obligations under the *Community Treatment Plan*.

______________________________ X ______________________________
Printed Name of Supervising Medical Practitioner Signature

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

ii.) Adding Monitoring Arrangement(s) to *Community Treatment Plan*

The following outlines the additional monitoring support(s) arranged for the patient:

Name of Monitor		Telephone
Street	Community	Postal Code
Other Contact Information		

☐ Substitute decision maker ☐ Family member (specify): ____________ ☐ Other (specify): ____________

Description of monitoring:

Name of Monitor		Telephone
Street	Community	Postal Code
Other Contact Information		

☐ Substitute decision maker ☐ Family member (specify): ____________ ☐ Other (specify): ____________

Description of monitoring:

I, ______________________________ (Supervising Medical Practitioner) of ______________________________ (Facility),

have consulted with and obtained a written agreement from the above substitute decision maker, family members, or other persons in respect of the performance of their roles and obligations under the *Community Treatment Plan*. Such agreement includes consent to disclose each substitute decision maker, family member, and other person's name to any other person or body named in the *Community Treatment Plan*.*

______________________________ Printed Name of Supervising Medical Practitioner

X ______________________________ Signature

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

**Attach all written agreements to the completed* Community Treatment Plan Amendment*.*

iii.) Amending monitoring arrangement(s) under the *Community Treatment Plan*		
The following person(s) monitoring arrangement(s) made under the *Community Treatment Plan* are amended by substituting:		
Name of Monitor		Telephone
Street	Community	Postal Code
Other Contact Information		
☐ Substitute decision maker	☐ Family member (specify): ______	☐ Other (specify): ______
Description of monitoring:		
Name of Monitor		Telephone
Street	Community	Postal Code
Other Contact Information		
☐ Substitute decision maker	☐ Family member (specify): ______	☐ Other (specify): ______
Description of monitoring:		

I, ______________________ of ______________________,
(Supervising Medical Practitioner) (Facility)

have consulted with and obtained a written agreement from the above substitute decision maker, family members, or other persons in respect of the performance of their roles and obligations under the *Community Treatment Plan*. Such agreement includes consent to disclose each substitute decision maker, family member, and other person's name to any other person or body named in the *Community Treatment Plan*.*

______________________ X ______________________
Printed Name of Supervising Medical Practitioner Signature

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

**Attach all written agreements to the completed* Community Treatment Plan Amendment*.*

D. ADDITIONAL TERMS AND CONDITIONS **Attach additional page if more space is required.*

The following changes are required to the additional terms and conditions made under the *Community Treatment Plan* (please indicate below and fill out applicable section(s)):

☐ **i.) Removing term(s)s and/or condition(s) from *Community Treatment Plan***

☐ **ii.) Adding additional term(s)s and/or condition(s) to *Community Treatment Plan***

i.) Removing term(s)s and/or condition(s) from *Community Treatment Plan*

The following terms and conditions are removed from the *Community Treatment Plan*:

ii.) Adding additional term(s)s and/or condition(s) to *Community Treatment Plan*

The following additional terms and conditions are added to the *Community Treatment Plan*:

PART 2: OTHER SUPPORTS

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

The patient must reside at the NEW address listed below:

Street Address	Community	Postal Code
Mailing Address	Community	Postal Code

Phone Number	Email Address

If additional supports have been determined to be necessary to maintain stable housing as listed above, please list these supports and contact information in the space below:

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

The following changes are required to the income sources under the *Community Treatment Plan* (please indicate below and fill out applicable section(s)):

☐ **i.) Removing income source(s) from *Community Treatment Plan***

☐ **ii.) Adding income source(s) to *Community Treatment Plan***

i.) Removing Income Sources from *Community Treatment Plan*

The following source(s) of income are removed from the *Community Treatment Plan*:

Resource/Agency/Contact	Statement of Stable Income

ii.) Adding Income Source(s) to *Community Treatment Plan*

The following source(s) of income are added to the *Community Treatment Plan*:

Resource/Agency/Contact	Statement of Stable Income

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

The following changes are required to the other supports made under the *Community Treatment Plan* (please indicate below and fill out applicable section(s)):

☐ **i.) Removing other support(s) from *Community Treatment Plan***

☐ **ii.) Adding other support(s) to *Community Treatment Plan***

i.) Removing other support(s) from *Community Treatment Plan*

The following supports are removed from the *Community Treatment Plan*:

ii.) Adding other support(s) to the *Community Treatment Plan*

The following supports are added to the *Community Treatment Plan*:

Distribution Note:
Within **24 hours** of issuing this form:

- It must be filed with the director of the designated facility where the patient is admitted involuntarily**.**
- A copy must be provided to the patient, and if applicable, the patient's substitute decision maker**.**

Copies of this form need to be provided to, if applicable:

(a) Person designated by patient to receive information
(b) A person with lawful custody or authority if the patient is a minor
(c) Legal guardian
(d) Agent under a personal directive
(e) Relative (with patient's consent if (a) to (d) do not apply)

Additional Actions Required:

- This amendment must be attached to the **original** *Assisted Community Treatment Certificate* and *Community Treatment Plan* and be accompanied by any *Assisted Community Treatment Certificate Amendment* (if applicable).
- Attach all written agreements to the completed *Community Treatment Plan Amendment*.

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.