



**FORM 27 – Northwest Territories Mental Health Act**

**CERTIFICATE REQUIRING PATIENT TO ATTEND MANDATORY ASSESSMENT AT HEALTH FACILITY**

This certificate requires the involuntary patient who is subject to an *Assisted Community Treatment Certificate* to attend a mandatory assessment. The assessment will determine if the conditions and effectiveness of the *Community Treatment Plan* are being adequately met.

Name of Patient		Gender				
Health Care Number		Date of Birth (DD-MM-YYYY)				
<b>Address of Patient</b>						
Street		Community		Postal Code		
<b>Designated Facility (where admitted)</b>						
Name						
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
<i>Certificate of Involuntary Admission</i>						
<i>OR Renewal Certificate</i>						
Current Assisted Community Treatment Certificate	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
<i>Assisted Community Treatment Certificate</i>						

**TO BE COMPLETED BY THE SUPERVISING MEDICAL PRACTITIONER OR DIRECTOR ISSUING CERTIFICATE**

I, \_\_\_\_\_ of \_\_\_\_\_,  
(Supervising Medical Practitioner/Director of Designated Facility) (Address)

require \_\_\_\_\_ to attend a mandatory assessment for the following reason(s):  
(Full Name of Patient)

- The patient has failed to comply with one or more of the conditions of the *Community Treatment Plan*; **AND**
- An assessment is required to determine the effectiveness of the *Community Treatment Plan* and whether the involuntary admission criteria continue to be met; **AND**
- The patient has failed to or refused to attend an appointment(s) for an assessment as outlined in the *Community Treatment Plan*.

**The following information supports my opinion:**

Facts and rationale:

Please indicate what evidence (*Community Treatment Plan Reports*, documentation of review of patient's obligations, etc.) has been provided to show efforts were made to:

(a) Assist patient to comply with the *Community Treatment Plan*:

(b) Inform patient of their failure to comply with a condition or conditions of the *Community Treatment Plan*:

(c) Inform patient of the possible consequences of failure to comply with the *Community Treatment Plan*:

*Please attach all evidence listed above to this certificate.*

**I therefore authorize that the person named in this certificate be apprehended by a peace officer and conveyed to**

\_\_\_\_\_ **at** \_\_\_\_\_  
(Name of health facility) (Address)

**for an involuntary psychiatric assessment. The authority of this certificate lasts for 30 days and will expire on** \_\_\_\_\_ .  
Date (DD-MM-YYYY)

Supervising Medical Practitioner/Director of Designated Facility \_\_\_\_\_ **X** \_\_\_\_\_  
Signature

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ at \_\_\_\_\_ .  
(Time)

**Distribution Note:**

- This form must be filed with the director of the designated facility where the patient is admitted involuntarily.
- Copies need to be provided to the patient, and if applicable:
  - (a) Substitute decision maker
  - (b) Person designated by patient to receive information
  - (c) A person with lawful custody or authority if the patient is a minor
  - (d) Legal guardian
  - (e) Agent under a personal directive
  - (f) Relative (with patient's consent if (a) to (e) do not apply)

**Additional Actions Required:**

- 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 ext. 49164 or [mentalhealth\\_act@gov.nt.ca](mailto:mentalhealth_act@gov.nt.ca)