



FORM 28 – Northwest Territories Mental Health Act

CERTIFICATE CANCELLING ASSISTED COMMUNITY TREATMENT CERTIFICATE

A *Certificate Cancelling Assisted Community Treatment Certificate* is used when a supervising medical practitioner or director of the designated facility is of the opinion that the involuntary patient continues to meet the involuntary admission criteria, but requires supervision and treatment or care in a designated facility.

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	
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>					
OR Renewal Certificate					
Assisted Community Treatment Certificate being cancelled	Date of Issue (DD-MM-YYYY)	Time of Issue	Name of Medical Practitioner who Issued Certificate		
<i>Assisted Community Treatment Certificate</i>					

TO BE COMPLETED BY SUPERVISING MEDICAL PRACTITIONER OR DIRECTOR OF THE DESIGNATED FACILITY ISSUING CERTIFICATE

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

cancel the *Assisted Community Treatment Certificate* issued for _____
(Full Name of Patient)

In my professional opinion, the cancellation of the *Assisted Community Treatment Certificate* is based on the following:

The involuntary admission criteria continue to be met; and as a result of a change in the mental condition of the patient or other circumstances, the patient requires supervision and treatment or care in a designated facility.

OR

Services under the *Community Treatment Plan* have become unavailable and other suitable services could not be arranged.

The following information supports my opinion:

_____ must return to _____ immediately.	_____
(Patient Name)	(Name and Address of Designated Facility)

Please contact the person listed below to arrange your travel back to the designated facility:	
Name	Phone Number

_____ Printed Name of Supervising Medical Practitioner/ Director of Designated Facility	X _____ Signature
Dated this _____ day of _____, 20____ at _____ . <div style="text-align: right; font-size: small;">(Time)</div>	

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:

- **Notice of cancellation must be provided, within 24 hours**, to all health professionals and other persons or bodies named in the *Community Treatment Plan*.
- If the patient does not return to the designated facility, the attending medical practitioner or director of the designated facility must issue an *Unauthorized Absence Statement* to have the patient apprehended by a peace officer and returned to the facility.
- **Within 72 hours** of the patient’s return to the designated facility, the attending medical practitioner must conduct a psychiatric assessment of the patient to determine whether the involuntary admission criteria continue to be met.

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