

**FORM 29 – Northwest Territories Mental Health Act**

# **NOTICE REQUIRING PATIENT TO RETURN TO DESIGNATED FACILITY ON EXPIRATION OF ASSISTED COMMUNITY TREATMENT CERTIFICATE**

This form notifies you that the *Assisted Community Treatment Certificate* is **expiring** and you are to **return to the designated facility**.

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	
<b>Current Involuntary Admission Certificate</b>	<b>Date of Issue (DD-MM-YYYY)</b>	<b>Time of Issue</b>	<b>Name of Attending Medical Practitioner who Issued Certificate</b>	<b>Date of Expiry (DD-MM-YYYY)</b>	<b>Time of Expiry</b>
<i>Certificate of Involuntary Admission</i>					
<b>OR Renewal Certificate</b>					
<b>Current Assisted Community Treatment Certificate</b>	<b>Date of Issue (DD-MM-YYYY)</b>	<b>Time of Issue</b>	<b>Name of Medical Practitioner who Issued Certificate</b>	<b>Date of Expiry (DD-MM-YYYY)</b>	<b>Time of Expiry</b>
<i>Assisted Community Treatment Certificate</i>					

_____ <b>must return to</b> _____ (Patient Name) (Name and Address of Designated Facility)	
by _____ . Date (DD-MM-YYYY) Time	

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

_____ Printed Name of Supervising Medical Practitioner	X _____ Signature
Dated this _____ day of _____, 20____ at _____ . (Time)	

**Distribution Note:**

- This notice must be provided to the patient **at least 14 days before** the expiry of the *Assisted Community Treatment Certificate*.
- A copy of this notice must be provided to the health professionals and other persons and bodies named in the *Community Treatment Plan* **within 24 hours** of providing the notice to the patient.

**Additional Actions Required:**

- If the patient does not return to the designated facility by the date and time specified in this notice, 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](mailto:mhact_reviewboard@gov.nt.ca)