Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 4 – *Northwest Territories Mental Health Act*

RENEWAL CERTIFICATE

This certificate authorizes the continued involuntary admission of a patient to the specified designated facility for up to **30 days** (first renewal), **60 days** (second renewal), **or 90 days** (third and subsequent renewals). It further authorizes the detention and control of the person for these purposes.

* *Note: this certificate must be issued within **72 hours before** the expiration of the patient's* Certificate of Involuntary Admission *or* Renewal Certificate

Name of Patient			Gender
Health Care Number			Date of Birth (DD-MM-YYYY)
Patient Address			
Street	Community		Postal Code
Designated Facility (where admitted)			
Name			
Street	Community		Postal Code
Designated Facility (where examined – if different from above)			
Name			
Street	Community		Postal Code
Current *Certificate of Involuntary Admission* or *Renewal Certificate*			
Date of Issue (DD-MM-YYYY)	Time of Issue	Date of Expiry (DD-MM-YYYY)	Time of Expiry

This *Renewal Certificate* is the:

☐ First Renewal ☐ Second Renewal ☐ Third Renewal ☐ _____ Renewal

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING CERTIFICATE

I, _____ (Attending Medical Practitioner), of _____ (Address), personally examined

_____ (Full Name of Patient) of _____ (Community)

on _____ (DD-MM-YYYY) at _____ (Time).

In my professional opinion, the patient continues to meet the criteria for involuntary admission:

☐ (a) is suffering from a mental disorder;

☐ (b) because of the mental disorder, is likely to cause serious harm to themselves or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment if they are not admitted as an involuntary patient; and

☐ (c) is not suitable to be admitted as a voluntary patient.

The patient must meet all of the criteria outlined above for the Attending Medical Practitioner to issue the certificate.

The following information supports my opinion that the patient meets the criteria as checked above:
Facts personally observed during examination:
Facts communicated by others/other information:
Differential diagnosis and/or diagnosis:

The patient named in this certificate will continue to be an involuntary patient at the designated facility.

This certificate is valid for up to _____ **days, and expires on** _____ **at** _____ **.**
(30, 60, 90) (DD-MM-YYYY) (Time)

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

PLEASE PRINT FORM TO SIGN

_____ X _____
Printed Name of Attending Medical Practitioner Signature

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:

- Complete *Notification of Patient Rights and Other Information* form **at earliest opportunity**.

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