



**FORM 5 – Northwest Territories Mental Health Act**

**CANCELLATION OF CERTIFICATE OF INVOLUNTARY ADMISSION OR OF RENEWAL CERTIFICATE**

This form indicates a patient that was subject to a *Certificate of Involuntary Admission* is no longer an involuntary patient and may leave the designated facility or request to remain as a voluntary patient. The person must be released from the designated facility unless the admission status is changed and the patient consents to a voluntary admission.

|   |  |   |
|---|--|---|
| Name of Patient   | Gender                                       |   |
| Health Care Number  | Date of Birth (DD-MM-YYYY)                   |   |
| <b>Patient Address</b>  |  |   |
| Street  | Community                                    | Postal Code                                 |
| <b>Designated Facility</b> (where admitted)                   |  |   |
| Name  |  |   |
| Street  | Community                                    | Postal Code                                 |
| <b>Facility</b> (where assessed – if different from above)    |  |   |
| Name  |  |   |
| Street  | Community                                    | Postal Code                                 |
| <b>Certificate Being Cancelled</b>                            |  |   |
| <input type="checkbox"/> Certificate of Involuntary Admission | <input type="checkbox"/> Renewal Certificate |   |
| Date of Issue (DD-MM-YYYY)                                    | Time of Issue                                | Medical Practitioner who issued Certificate |

**TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING THE CANCELLATION**

I, \_\_\_\_\_, of \_\_\_\_\_, personally examined \_\_\_\_\_, (Address)  
(Attending Medical Practitioner)

of \_\_\_\_\_ (Community)  
(Full Name of Patient)

on \_\_\_\_\_ at \_\_\_\_\_.  
(DD-MM-YYYY) (Time)

**In my professional opinion, the following information supports my opinion that the patient no longer meets the criteria for an involuntary admission:**

Facts personally observed during examination:

Facts communicated by others/other information:

**The patient named in this cancellation may leave the designated facility or request to remain as a voluntary patient.**

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

Printed Name of Attending Medical Practitioner

X

Signature

**Distribution Note:**

- This form must be filed with the director of the designated facility where the patient was admitted involuntarily.

**Additional Actions Required:**

- Notice of cancellation, including the expected date and time of release, needs to be provided to:
  - (a) the patient
  - (b) all other persons provided with a copy of the *Certificate of Involuntary Admission* and/or *Renewal Certificate*
  - (c) the health professional at the health facility where the person will receive follow-up treatment
  - (d) if the person was subject to an *Assisted Community Treatment Certificate*, all health professionals and other persons or bodies named in the *Community Treatment Plan*, **within 24 hours**
- If a *Certificate of Mental Incompetence* is in force, the director of the designated facility where the patient was admitted must provide notice to the Public Trustee that the person is no longer an involuntary patient.

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)

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.