Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

**FORM 7 – *Northwest Territories Mental Health Act***

# AUTHORIZATION TO TRANSFER INVOLUNTARY PATIENT TO FACILITY WITHIN THE NORTHWEST TERRITORIES

This form authorizes the transfer of an involuntary patient from the designated facility to another designated facility or health facility **within the Northwest Territories**. It authorizes the conveyance, detention, and control of the patient by a peace officer or other authorized person for the purposes of the transfer.

| | | |
|---|---|---|
| Name of Patient | | Gender |
| Health Care Number | | Date of Birth (DD-MM-YYYY) |
| **Address of Patient** | | |
| Street | Community | Postal Code |
| **Transferring Designated Facility** | | |
| Name | | |
| Street | Community | Postal Code |
| **Receiving Facility** | | |
| Name | | |
| Street | Community | Postal Code |
| Contact Person | Title of Contact Person | |
| Contact Information | | |

## TO BE COMPLETED BY THE DIRECTOR OF THE TRANSFERRING DESIGNATED FACILITY

**In determining the best interests of** _____ **, I have:**
(Name of Patient)

- ☐ Consulted with the attending medical practitioner, the patient's other health care providers, and the patient and their substitute decision maker (if applicable);
- ☐ If applicable, considered the wishes of the patient, who is under a *Treatment Decision Certificate*, when they were mentally competent to make treatment decisions.

## TRANSFER ARRANGEMENTS

I, _____ of _____,
(Director of Designated Facility) (Name of Designated Facility)

believe that the transfer is in the best interest of _____ .
(Full Name of Patient)

I have made the necessary arrangements, and hereby authorize the transfer of the patient from

_____ to _____ .
(Name of Transferring Facility) (Name of Receiving Facility)

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

_____ X PLEASE PRINT FORM TO SIGN

Printed Name of Director of Designated Facility | Signature

**Additional Actions Required:**

- If the patient is under an *Assisted Community Treatment Certificate*, an *Assisted Community Treatment Certificate Amendment* is also 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 or mhact_reviewboard@gov.nt.ca