Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 8 – ***Northwest Territories Mental Health Act***

CERTIFICATE AUTHORIZING TRANSFER OF INVOLUNTARY PATIENT TO FACILITY OUTSIDE THE NORTHWEST TERRITORIES

This form authorizes the transfer of an involuntary patient from a designated facility in the Northwest Territories to a psychiatric facility or hospital **outside 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 Facility (IN NWT)			
Name			
Street	Community		Postal Code
Receiving Facility (OUTSIDE NWT)			
Name			
Street	Community	Province/ Territory	Postal Code
Contact Person	Title of Contact Person		
Contact Information			

TO BE COMPLETED BY THE DIRECTOR OF THE TRANSFERRING DESIGNATED FACILITY

I am authorizing the transfer of _____ **because (please check):**
(Name of Patient)

☐ **A.** I am satisfied that the transfer is in the best interests of the patient, following:

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

OR

☐ **B.** This patient has come or been brought into the Northwest Territories from elsewhere and the hospitalization is the responsibility of the jurisdiction to which the patient is to be transferred, **as supported by the following information**:

_____

_____

_____

OR

☐ **C.** I believe that the patient cannot be properly cared for, observed, examined, assessed, treated, detained or controlled in a health facility or designated facility in the Northwest Territories.

PATIENT/SUBSTITUTE DECISION MAKER CONSENT

If **A** or **B** above were selected as the reason for the transfer, the consent of the patient or substitute decision maker (if applicable) is required. Consent is **NOT** required if the transfer is due to the reasons outlined in **C** above.

I, _____, consent to the transfer as outlined above.
(Name of Patient or Substitute Decision Maker)

Name of Patient or Substitute Decision Maker	X _____ Signature of Patient or Substitute Decision Maker	Date (DD-MM-YYYY)

TRANSFER ARRANGEMENTS

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

have made the necessary arrangements, and hereby authorize the transfer of _____
(Full Name of Patient)

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

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

Printed Name of Director of Designated Facility	X _____ PLEASE PRINT FORM TO SIGN Signature

Distribution Note:

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:

- 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