Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 9 – *Northwest Territories Mental Health Act*

AUTHORIZATION TO TRANSFER A PATIENT TO A DESIGNATED FACILITY FROM A HEALTH FACILITY OUTSIDE THE NORTHWEST TERRITORIES

This form authorizes the transfer of a patient from a health facility **outside of the Northwest Territories** to a designated facility **in the Northwest Territories**. It authorizes the apprehension of the patient by a peace officer and 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 (OUTSIDE NWT)			
Name			
Street	Community	Province/ Territory	Postal Code
Contact Person	Title of Contact Person		
Contact Information			
Receiving Designated Facility (IN NWT)			
Name			
Street	Community		Postal Code

TO BE COMPLETED BY THE DIRECTOR OF THE RECEIVING DESIGNATED FACILITY IN THE NWT

I am satisfied that:

☐ **A.** The Government of the Northwest Territories is responsible for the hospitalization of _____, (Name of Patient)

as supported by the following information:

_____

_____

OR

☐ **B.** It would be in the best interests of _____ (Name of Patient) to be in a designated facility in the Northwest Territories, **as supported by the following information**:

_____

_____

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 Facility) (Name of Receiving Designated 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:

- 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