Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

FORM 2 – *Northwest Territories Mental Health Act*

CERTIFICATE OF INVOLUNTARY ASSESSMENT

This certificate authorizes the apprehension of a person by a peace officer, and the conveyance of that person by a peace officer or other authorized person to the specified designated facility for **up to 7 days after the certificate is issued**. Once at the facility, this certificate authorizes the involuntary care, observation, examination, assessment, and treatment of that person for **up to 72 hours**. It further authorizes the detention and control of the person for these purposes.

** Note: this certificate must be issued within 24 hours of completing the examination.*

Name of Person		Gender
Health Care Number		Date of Birth (DD-MM-YYYY)
Address of Person (community of residence at time of examination)		
Street	Community	Postal Code
Facility (where examined)		
Name		
Street	Community	Postal Code

TO BE COMPLETED BY HEALTH PROFESSIONAL ISSUING CERTIFICATE

I, ______________________ (Name of Health Professional), a ______________________ (Health Profession), personally examined

______________________ (Full Name of Person) of ______________________ (Community)

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

In my professional opinion, the person:

- ☐ (a) is suffering from a mental disorder;
- (b) because of the mental disorder, the person
  - ☐ (i) is likely to cause serious harm to themselves or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment,
    OR
  - ☐ (ii) has recently caused serious harm to themselves or to another person, or has threatened or attempted to cause such harm;
    AND
- ☐ (c) the person should undergo an involuntary psychiatric assessment to determine whether they should be admitted to a designated facility as an involuntary patient.

The person must meet the criteria outlined in sections a, one of b (i) or (ii), and c for the health professional to issue the certificate.

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

The person named in this certificate:

☐ Is already at a designated facility and will receive an involuntary psychiatric assessment at the facility where they are currently located.

OR

☐ Requires apprehension and conveyance to a designated facility to receive an involuntary psychiatric assessment, as outlined below:

Designated Facility where person is to be conveyed for involuntary psychiatric assessment		
Name		
Street	Community	Postal Code
Expiration of Authority to apprehend and convey *(*7 days after issuance of certificate)*		
Date (DD-MM-YYYY)	Time	

Printed Name of Health Professional	X Signature

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

Distribution Note:

- This form must be filed with the director of the designated facility where the person is to receive an involuntary psychiatric assessment.
- 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 apprehension and/or conveyance.
- 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

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.