The Regulation and Quality Improvement Authority

Guidance for the completion of Prescribed Forms (Forms 1–12) under the Mental Health (NI) Order 1986

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Contents

Definitions

Consultant Psychiatrist	A medical practitioner appointed to consultant grade, who specialises in the diagnosis and treatment of mental disorders
Part II Medical Practitioner	Consultant Psychiatrist appointed to the RQIA List of Part II Medical Practitioners for the purposes of Part II of The Mental Health (Northern Ireland) Order 1986
Part IV Medical Practitioner	Consultant Psychiatrist appointed to the RQIA List of Part IV Medical Practitioners for the purposes of Part IV of The Mental Health (Northern Ireland) Order 1986
Approved Social Worker	A Social Worker who has undertaken specific training to assume duties in accordance with The Mental Health (Northern Ireland) Order 1986
Responsible Medical Officer	The Consultant Psychiatrist (usually a Part II doctor) in charge of the patient's assessment or treatment

The Regulation and Quality Improvement Authority

Who We Are

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability team (MHLD) undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. These include:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

The MHLD team talks directly to patients about their experiences. This informs the wider programme of announced and unannounced inspections.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements. Inspection report can be viewed on our website at http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability.cfm

Monitoring of Detention and other Prescribed Forms by the Mental Health and Learning Disability Directorate

Detention is defined as the deprivation of liberty or the imprisonment or placement of a person who is detained under legislation in a public or private institutional setting, which they are not permitted to leave at will. The prescribed forms used in the processes of detention for assessment or treatment in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO) provide legal justification for staff who take actions under the MHO.

Errors or defects in an application for assessment, in the medical recommendation on which it is based, or in one of the medical reports, may mean that the authority for the detention of the person is open to legal challenge and could be found to be invalid.

RQIA is required at Article 86 (2) of the MHO to scrutinise all prescribed forms associated with detention processes, and advise Health and Social Care Trusts if there are any errors or omissions which may make the detention or guardianship process improper.

Standards and General Principles

This document provides guidance and clarity for those completing prescribed forms in terms of the information that must be recorded and the manner in which the forms should be completed.
Supporting guidance and clarity for those completing prescribed forms can be found in the following documents:

- The Mental Health (NI) Order, 1986
- The Mental Health (NI) Order, 1986, A Guide
- The Mental Health (NI) Order, 1986, Code of Practice
- The GAIN Guidelines (October 2011) on the use of the Mental Health (NI) Order, 1986.

The role of hospital staff in the receipt and scrutiny of documents is described at Sections 2.52 – 2.56 of the Code of Practice. The responsibility of the receiving medical and nursing staff in assuring the validity of the documentation is explicit.
The general principles that should be applied to ensure the validity of the documentation include:

- All parts must be completed legibly
- All parts must be completed fully
- Full names of patients and all practitioners involved - **NO** use of abbreviations or initials is permitted
- Full names and addresses of Trusts and Hospital – **NO** use of abbreviations is permitted
- Addresses must include postcodes
- Doctors status should be clearly indicated where required
- Forms must be signed, dated (and timed where required) within the timescales required in the MHO
- The information recorded must contain sufficient detail to ensure the legal validity for detention

Provisions for Amendments of Errors and Omissions

It is a requirement of the legislation that prescribed forms are forwarded to RQIA by the Trusts. It is important that completed prescribed forms are forwarded to RQIA once they have been completed. These forms should be received by RQIA no later than **four** days following completion.
Article 11 of the MHO allows some amendment of prescribed forms associated with applications, recommendations and reports by the person who signed the form, providing they are received within 14 days from the date of the patient's admission to hospital.

However, errors and/or omissions noted outside of the 14 day timescale cannot be rectified. Consequently, the entire application may become invalid, and the detention deemed improper. If the patient still requires to be detained in hospital, the process must start from the beginning.

Please note that RQIA cannot accept forms which are illegible, incomplete or include errors/omissions.

Form 1

Form 1
Mental Health
(Northern Ireland)
Order 1986
Article 4

APPLICATION BY NEAREST RELATIVE FOR ADMISSION FOR ASSESSMENT

(Before completing this form please read the notes overleaf)

(name and address of responsible authority) To

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

(Full name and address of applicant) I,

Make sure the applicant's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the applicant's address is written out in FULL including postcode.

hereby apply for the admission of

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

(Name of hospital) to

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

Delete (a) or (b)

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Order. I am the patient's

(state relationship)

i.e. father, mother, sister, brother, husband, wife, etc

(b) I have been authorised by a county court to exercise the functions under the Order of the patient's nearest relative. A copy of the court order is attached to this application.

(date) I last saw the patient on

This date should be the same as or within 48 hours prior to the date at the bottom of the form

This application is founded on and accompanied by a medical recommendation in the prescribed form.
If the medical practitioner did not know the patient before making his/her recommendation, please explain why you could not get a recommendation from a medical practitioner who did know the patient: -

An explanation should ONLY be given here if the GP who signed the Form 3 is NOT from the practice the patient is registered with. Any GP from within the practice is considered to be the 'patient's medical practitioner'.

MAKE SURE FORM IS SIGNED AND DATED!

Signed: _____ Date: _____

Notes

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. (i.e.) BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of the MHO.
Full name of applicant address of applicant	Make sure the applicant's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure that the applicants address is written out in **FULL** including postcode.
Full Name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including the postcode and is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
State Relationship	i.e. father, mother, sister, brother, husband , wife, etc.
Last saw the patient on (Date)	This date should be the same as or within 48 hours prior to the date at the bottom of the form.
Reason for lack of recommendation from a medical practitioner who knew the patient	An explanation should **ONLY** be given here if the GP who signed the Form 3 is **NOT** from the practice the patient is registered with. Any GP from within the practice is considered to the

	‘patient’s medical practitioner’, as is any GP working for an Out of Hours Service
Signed and Dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 2

APPLICATION BY AN APPROVED SOCIAL WORKER FOR ADMISSION FOR ASSESSMENT

FORM 2
Mental Health
(Northern Ireland)
Order 1986
Article 4

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

Full name of applicant
address of applicant

I

Make sure the Approved Social Worker's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's OFFICE address is written out in FULL including postcode.

hereby apply for the admission of

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

(Name of hospital)

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(Name of Trust)

I am the officer d

Make sure the FULL name of the Trust is given i.e. BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST depending on whichever Trust the ASW works for.

appointed to act as an approved social worker for the purposes of the Order.

The following section should be completed if nearest relative consulted

Delete either (a) or (b) AND either (c) or (d) as appropriate

(name and address) (a)

I have consulted:

who, to the best of my knowledge and be
meaning of the Order.

OR

(name and address) (b)

(I have consulted:

The ASW has a duty to ensure that the nearest relative is correct according to the notes on the rear of the Form 1 – Articles 32-36 of the Order.
If the nearest relative IS consulted the ASW should then fill in the details IN FULL in the box at (a), and strike out option (b).
If the nearest relative has NO OBJECTION to the application, the ASW should strike out the option at box (d).
If the nearest relative HAS an objection the ASW should strike out the option at (c) and complete the appropriate deletion at (d). The ASW should then complete the section at the top of the next page.

who I understand has been authorised by a county court to exercise the functions under the Order of the patient's nearest relative.

AND

(c) That the person has not notified me or the responsible Trust that he/she objects to this application being made.

OR

(d) That the person has notified
*~~me~~ the responsible trust that he/she objects to this application being made and

***(Delete whichever does not apply)**

Please turn over

(name and office address of approved social worker)

I have consulted:

IF REQUIRED - Make sure the Approved Social Worker's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's OFFICE address is written out in FULL including postcode.

(name of Trust)

an officer of: Make sure the FULL name of the Trust is given IF REQUIRED.

appointed to act as an approved social worker for the purposes of the Order.

The following section should be completed if nearest relative not consulted

Delete (i), (ii), or (iii) as appropriate

If the nearest relative HAS NOT BEEN CONSULTED the ASW should complete this section (and should have deleted options A to D on the previous page). Two of these three options should be stricken out.
If option three applies, then ASW should fill in the details of the nearest relative IN FULL.

(i) I have been unable to ascertain who is t meaning of the Order

OR

(ii) To the best of my knowledge and belief the meaning of the Order

OR

*(Delete the phrase which does not apply)

(iii) In my opinion it * is not reasonably practicable / would involve unreasonable delay

to consult

(name and address)

*(Delete the phrase which does not apply)

who is * the patient's nearest relative / authorised to exercise the functions of the patient's nearest relative before making this application.

The following section should be completed in all cases

(DATE):

I last saw this patient on:

This date should be the same as or within 48 hours prior to the date at the bottom of the form

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

The application is founded on and accompanied by a medical recommendation in the prescribed form.

If the medical practitioner did not know the patient before making his/her recommendation, please explain why you could not get a recommendation from a medical practitioner who did know the patient:-

An explanation should ONLY be given here if the GP who signed the Form 3 is NOT from the practice the patient is registered with. Any GP from within the practice is considered to be the 'patient's medical practitioner'.

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ **Dated** _____

Notes

Approved Social Workers completing Form 2 must ensure that the application for admission for assessment is supported by a fully completed medical recommendation (Form 3) clearly stating the evidence for the detention.

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO.
Full name of applicant address of applicant	Make sure the Approved Social Worker's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's **OFFICE** address is written out in **FULL** including postcode.
Full Name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Name of Trust	Make sure the **FULL** name of the Trust is given i.e. BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST depending on whichever trust the ASW works for. No abbreviations will be accepted. Ensure postcode is included.

Name and address (a)	The ASW has a duty to ensure that the nearest relative is correct according to the notes on the rear of the Form 1 – Articles 32-36 of the Order. If the nearest relative IS consulted the ASW should then fill in the details **IN FULL** in the box a t (a), and strike out option (b). If the nearest relative has **NO OBJECTION** to the application, the ASW should strike out the option at box (d). If the nearest relative **HAS** an objection the ASW should strike out the option at (C) and complete the appropriate deletion at (d). The ASW should then complete the section at the top of the next page.
Name and address (b)	
Name and address (c)	
Name and address (d)	
Name and office address of Approved Social Worker	**IF REQUIRED** – Make sure the Approved Social Worker's **FULL LEGAL** name is used here. **NO** abbreviations or initials should be used. Ensure the Approved Social Worker's **OFFICE** address is written out in **FULL** <u>including</u> postcode.
Name of Trust	**IF REQUIRED** - Make sure the **FULL** name of the Trust is given.
If nearest relative has not been consulted	**IF REQUIRED** - If the Nearest relative **HAS NOT BEEN CONSULTED** the ASW should complete this section (and should have deleted options A to D on the previous page). Two of these three options should be stricken out. If option three applies, then ASW should fill in the details of the nearest relative **IN FULL**.
Last saw this patient on (Date)	This date should be the same as or within 48 hours prior to the date at the bottom of the form.
Medical Practitioners	**IF REQUIRED** - An explanation should **ONLY** be given here if the GP who signed the Form 3 is **NOT** from the practice the patient is registered with. Any GP from within the practice is considered to be the patient's medical practitioner.
Signed and Dated	**MAKE SURE THE FORM IS SIGNED AND DATED**

Form 3

MEDICAL RECOMMENDATION FOR ADMISSION FOR ASSESSMENT

FORM 3
Mental Health
(Northern Ireland)
Order 1986
Articles 4 and 6

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name and professional address of Medical practitioner)

I

Make sure the GP's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the GP's OFFICE address is written out in FULL including postcode.

a medical practitioner, recommend that

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

be admitted to hospital for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(Date) I last examined this patient on:

This date should be the same as or within 48 hours prior to the date at the bottom of the form

*(Delete if not Applicable)

*I am the patient's medical practitioner.
OR
*I had previous acquaintance with the patient before I conducted that examination.

Any GP from within the practice at which the patient is registered is considered to be the 'patient's medical practitioner' and option 2 should be deleted.
If the GP has previous acquaintance with the patient but is NOT their GP then option 1 should be deleted.
If the GP is neither the patient's GP nor has previous acquaintance with the patient an explanation should be given on whichever of the Form 1 or Form 2 is completed following this Form's completion, and both of these options should be deleted.

I am of the opinion: -

a) that the patient is suffering from mental disorder of a nature or degree which warrants his/her detention in a hospital for assessment (or for assessment followed by the medial treatment);

AND

b) that failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

My opinion at (a) above is based on the following grounds: -

(Give a clinical description of the patient's mental condition).

Ensure that the GP has provided a clinical description of the patient's mental condition. i.e. there must be some form of LEGIBLE text written here.

My opinion at (b) above is based on the following evidence: -
(Have regard only to evidence-

(i) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself;

OR

Please turn over

(ii) that the patient's judgement is so affected that he/she is, or would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(iii) that the patient has behaved violently towards other persons;

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves).

Ensure that the GP has provided evidence of the patient's mental condition. i.e. there must be some form of LEGIBLE text written here.

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ Date _____

***A doctor on the staff of the hospital in which the patient is being detained MAY ONLY sign the Form 3 following a Form 5 if the 48 hour period allowed by the Form 5 has almost elapsed and EVERY ATTEMPT to contact a community GP has been made and evidence of same is recorded in the clinical notes and on the Form 2 or 1 as applicable.**

Notes

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO.
Full name and professional address of Medical practitioner	Make sure GP's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the GP's **OFFICE** address is written out in **FULL** including Postcode. If the GP is not the patient's GP but is undertaking the assessment as part of an out of hours service which the patient's GP is part of, the GP should record the address of the out of hours office.
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Last examined patient on (Date)	This date should be the same as or within 48 hours prior to the date at the bottom of the form.
Patient relationship (Delete if not applicable)	Any GP from within the practice at which the patient is registered is considered to be the patient's 'medical practitioner' and Option 2 should be deleted. If the GP has previous acquaintance with the patient but is NOT their GP then Option 1 should be deleted.

	If the GP is neither the patient's GP nor has previous acquaintance with the patient an explanation should be given on whichever of the Form 1 or Form 2 is completed following this form's completion, and both of these options should be deleted.
Stated reason for Opinion (a)	Ensure that the GP has provided a clinical description of the patient's mental health condition, i.e. there **must** be some form of **LEGIBLE** text written here. The clinical description must describe the patient's mental condition and the patient's symptoms, **not** merely a diagnostic classification Please refer to Section 23 of The Guide.
Stated reason for Opinion (b)	Ensure that the GP has provided evidence of the patient's mental condition to support the opinion that failure to detain the patient would create a substantial likelihood of serious physical harm to himself or others. There **must** be some form of **LEGIBLE** text written here. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 3, supporting the medical opinion that the patients should be detained in hospital for medical assessment. This form must include sufficient detail to support the legal grounds for a patient's detention in hospital.
Sign and Date	**MAKE SURE THE FORM IS SIGNED AND DATED.**
Note: A doctor on the staff of the hospital in which the patient is being detained may ONLY sign the Form 3 following a Form 5 if the 48 hour period allowed by the Form 5 has almost elapsed and EVERY attempt to contact a community GP has been made. Evidence of same must be recorded in the clinical notes and on the Form 2 or 1 as applicable	

Form 4

MEDICAL CERTIFICATE TO EXTEND TIME LIMIT FOR CONVEYING PATIENT TO HOSPITAL

FORM 4
Mental Health (Northern Ireland Order1986
Article 8(1)

An application for assessment in respect of

(full name and address of patient)

Make sure the patients FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcodes and is consistent with ALL other forms completed.

has been duly completed in accordance with part II of the Mental Health (Northern Ireland) Order 1986

(full name and professional address of medical practitioner)

I

Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including Postcode

am a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission

(state the number of days) I certify that it is necessary to extend to

the time limit for conveying the patient

(name of hospital) to

Insert name of hospital here

This extension is necessary due to the following exceptional circumstances:-
[State the exceptional circumstances which make the extension necessary.]

There must be some form of LEGIBLE text written here.

Signed _____ Date _____

MAKE SURE THE FORM IS SIGNED AND DATED

Notes

Information Required	Guidance
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Full name and professional address of medical practitioner	Make sure the RMO or other Part II doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the GP's OFFICE address is written out in **FULL** including postcode
Name of hospital	Insert name of hospital.
State exceptional circumstances of extension	There **must** be some form of **LEGIBLE** text written here.
Sign and date	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 5

MEDICAL PRACTITIONER'S REPORT ON HOSPITAL IN-PATIENT NOT LIABLE TO BE DETAINED

FORM 5
Mental Health
(Northern Ireland)
Order 1986
Article 7 (2)

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used.

A medical practitioner on the staff of

(Name of Hospital)

Insert Name of Hospital

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed

is an in-patient in this hospital but is not liable to be detained there under the Mental Health (Northern Ireland) Order 1986.

I hereby report for the purposes of Article 7 (2) of the Order that it appears to me that an application for assessment ought to be made in respect of this patient for the following reasons:

(Reasons should indicate why voluntary treatment is not or is no longer appropriate).

Make sure some form of LEGIBLE text is present to explain why voluntary treatment is no longer appropriate.

MAKE SURE FORM IS SIGNED AND DATED and TIME IS STATED!

Signed _____ **Date** _____

Time _____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name (doctor)	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used.
Name of hospital	Insert name of hospital
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Reasons why voluntary treatment is no longer appropriate	Make sure some form of **LEGIBLE** text is present to explain why voluntary treatment is no longer appropriate.
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED MUST BE STATED**

Form 6

NURSE'S RECORD IN RESPECT OF HOSPITAL IN-PATIENT NOT LIABLE TO BE DETAINED

Form 6
Mental Health (Northern Ireland) Order 1986
Article 7(3)

(Name and address of responsible authority)

To

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations will be accepted.

Ensure that the word 'Authority' is stated here – not 'Board' or 'Trust'

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

is receiving treatment for mental disorder as an in-patient in

(Name of hospital)

Insert name of hospital

, but is not liable to be detained there under the Mental Health (Northern Ireland) Order 1986.

It appears to me –

(a) that an application for assessment ought to be made in respect of this patient;

AND

(b) that it is not practicable to secure the immediate attendance of a medical practitioner for the purpose of furnishing a report under Article 7(2) of the Order.

(Full name of nurse)

I am

Make sure the nurse's FULL LEGAL name is used here. No abbreviations or initials should be used.

nurse registered -

*(a) in Part 3 (first level nurse trained in the nursing of persons suffering from mental illness)

*(b) in Part 4 (second level nurse trained in the nursing of persons suffering from mental illness (England and Wales))

*(c) in Part 5 (first level nurse trained in the nursing of persons suffering from learning disabilities)

*(d) in Part 6 (second level nurse trained in the nursing of persons suffering from learning disabilities (England and Wales))

*(e) in Part 7 (second level nurse (Scotland and Northern Ireland) who is assessed as competent in the nursing of persons suffering from mental illness or learning disabilities)

*(f) in Part 13 (nurse qualified following a course of preparation in mental health nursing)

*(g) in Part 14 (nurse qualified following a course of preparation in learning disabilities nursing)

of the professional register
*(delete if not applicable)

Signed: _____

Date: _____

Time: _____

Make sure the form is signed and dated, and time is stated.

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Full name (nurse)	Make sure the nurse's **FULL LEGAL** name is used here. No abbreviations or initials should be used.
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED MUST BE STATED**

Form 7

REPORT OF MEDICAL EXAMINATION IMMEDIATELY AFTER ADMISSION FOR ASSESSMENT

FORM 7
Mental Health
(Northern Ireland)
Order 1986
Article 9 (3)

(name and address of Responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(full name and professional address of first Medical practitioner)

I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(full name and address of patient) examined:

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

immediately after he/she was admitted to

(name of hospital)

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on

Whichever date is used here becomes the patient's 'DATE OF ADMISSION' throughout the whole period of the patient's detention. This date should carry through to ALL other forms in the same period of detention.

In my opinion this patient: -

*(Delete as appropriate)

Two of these 3 options should be deleted.
If option (ii) or (iii) is left undeleted the patient is VOLUNTARY and no other forms are required

***(i) should be detained in hospital for assessment in accordance with Part II of the Order.**

***(ii) should remain in hospital for assessment and he/she has agreed to do so on a voluntary basis.**

***(iii) does not require to remain in hospital.**

My opinion is based on the following grounds: -
(Give a clinical description of the patient's mental condition).

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

I did not give the medical recommendation on which the application for assessment in respect of the patient is founded.

*(Delete if not applicable)

*I am the patient's responsible medical officer.
OR
*I am a medical practitioner appointed for the purpos
Mental Health Commission.
OR
*I am the medical practitioner on the staff of

Two of these 3 options should be deleted.
A Consultant should use option 1 or 2 and delete other options.
Junior Medical Staff should use option 3 and delete options 1 & 2

(name of hospital)

Insert Name of Hospital

MAKE SURE FORM IS SIGNED AND DATED and TIME IS STATED! (Date should be same as above)

Signed _____ Date _____ Time _____

Notes

This form must be completed by the examining medical practitioner immediately after admission for assessment. The date this form is completed is classified as **Day 1.**

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name and professional address of first Medical Practitioner	Make sure the doctors **FULL LEGAL** name is used here. No abbreviation or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Full name and address of patient examined	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Name of hospital	Inset name of hospital
Date	Whichever date is used here becomes the patient's '**DATE OF ADMISSION'** throughout the whole period of the patients detention. This date should carry through to **ALL** other forms in the same period of detention.
Examination findings – (Delete as appropriate)	Two of these three options should be deleted. If option (ii) or (iii) is left undeleted the patient is **VOLUNTARY** and no other forms are required.

Clinical description of patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.
Doctor patient relationship – (Delete if applicable)	Two of these three options should be deleted. A Consultant should use option 1 or 2 and delete other options. Junior Medical Staff should use option 3 and delete options 1 and 2.
Name of hospital	Insert name of hospital – ensure text is **LEGIBLE**
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED <u>MUST</u> BE STATED**

Form 8

EXTENSION OF ASSESSMENT PERIOD FROM 48 HOURS TO 7 DAYS – MEDICAL REPORT

Form 8
Mental Health (Northern Ireland) Order 1986
Article 9(6)

(name and address of responsible authority) To

Ensure that the word 'Authority' is stated here – not 'Board' or Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations will be accepted.

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

(name of hospital)

Insert name of hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on

MUST MATCH DATE STATED ON FORM 7

The medical practitioner who examined this patient immediately after he/she was so admitted to hospital was not the responsible medical officer or a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission.

(full name and professional address of medical practitioner) I,

Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including the Postcode

(date) examined this patient on

(time) at

This date must be within 48 hours of the time and date of Form 7 – counting the time of the Form 7 as Hour 1.

***(Delete if not applicable)**

*I am the patient's responsible medical officer.

OR

*It is not practicable for this examination to be carried out by the responsible medical officer. I am a medical practitioner appointed for the purposes of Part II of the Order by the Commission.

***(Delete if not applicable)**

In my opinion this patient –

*(I) should be detained in hospital for assessment for a further period.

*(ii) should remain in hospital for assessment and he/she has agreed to do so on a voluntary basis.

*(iii) does not require to remain in hospital.

Please turn over

This opinion is based on the following grounds:-

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Signed _____ Date _____

MAKE SURE FORM IS SIGNED AND DATED

Notes

This form should be completed by the Medical Practitioner within 48hours of admission if the examining doctor at admission was NOT the patient's RMO.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Date	**MUST MATCH DATE STATED ON FORM 7.**
Full name and professional address of Medical practitioner	Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including the Postcode.
Date – (Patient examined on)	This date must be within **48 hours** of the time and date of Form 7 – counting the time of the Form 7 as Hour 1.
Clinical description of patients mental health condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.

Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 9

MEDICAL REPORT TO EXTEND ASSESSMENT PERIOD FOR A FURTHER 7 DAYS

FORM 9
Mental Health
(Northern Ireland)
Order 1986
Article 9 (8)

(name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was admitted to

(name of hospital) Insert Name of Hospital

in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on **MUST MATCH DATE STATED ON FORM 7**

(full name and professional address of Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(date) examined this patient on

This date must be within 7 days of the date of the Form 7 – counting the date of the Form 7 as day 1

*(Delete if not applicable)

A Consultant should indicate whether he or she is the patient's RMO or not by deleting one o f these 2 options

***I am this patient's responsible medical officer.**

OR

***It is not practicable for this examination to be carried out by the responsible medical officer. I am a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission.**

In my opinion this patient should be detained in hospital for assessment for a further period.

This opinion is based on the following grounds: -

(Give a clinical description of the patient's mental condition).

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ **Date** _____

Notes

This form should be completed by the RMO within the **Days 3 – 7** to extend the assessment period for a second period of 7 days. The second 7 day period of assessment **does not start** until **Day 8**.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of Medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the trust is not required here.
Date – (Patient examined on)	This date must be within **7 days** of the date in Form 7 – continuing the date of the Form 7 as Day 1.
Declaration of RMO status or not. – (delete if not applicable)	A consultant should indicate whether he or she is the patient's RMO or not by deleting one of these two options.
Clinical description of	Ensure **LEGIBLE** text is written here to provide a

patient mental condition	clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 10

Form 10
Mental Health
(Northern Ireland)
Order 1986
Article 12

MEDICAL REPORT FOR DETENTION FOR TREATMENT

(name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital)

Insert Name of Hospital

(date) on

MUST MATCH DATE STATED ON FORM 7

(full name and professional address of medical practitioner)

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

a medical practitioner appointed for the purposes of Part II Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission, examined this patient

(date) on

This date must be within 14 days of the date of the Form 7 – counting the date of the Form 7 as day 1

In my opinion –

(a) this patient is suffering from

One of these options should be deleted UNLESS both apply

* (Delete if not applicable)

* mental illness
* severe mental impairment

of a nature or degree which warrants his/her detention in hospital for medical treatment:

AND

(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons

My opinion at (a) above is based on the following grounds:

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Please turn over

My opinion at (b) above is based on the following evidence:

(Have regard only to evidence-

(1) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself:

OR

(ii) that the patient's judgement is so affected that he/she would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(III) that the patient has behaved violently towards other persons:

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves:

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate).

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed_____ Date _____

Notes

The form must be completed within the second 7 day assessment period **Days 8** to **Day 14**.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviation or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here.
Date – (Patient examined on)	This date must be within **14 days** of the date of the Form 7, in the second seven day assessment period i.e. Days 8-14 – counting the date of the Form 7 as Day 1.
Opinion of medical practitioner – (delete if not appropriate)	One of these options should be deleted – **UNLESS** both apply.
Description of	Ensure **LEGIBLE** text is written here to provide a

Opinion stated in (a) – clinical description of patients mental condition	clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. Please refer to Section 46 of The Guide.
Opinion stated in (b) - clinical description of patients mental conditions	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 10, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital. Please refer to Section 46 of The Guide.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 11

FORM 11
Mental Health
(Northern Ireland)
Order 1986
Article 13 (2) and (5)

REPORT BY RESPONSIBLE MEDICAL OFFICER FOR RENEWAL OF AUTHORITY FOR DETENTION FOR 6 MONTHS OR ONE YEAR

(name and address of responsible Authority)

Insert Name and Address of Health and Social Care Trust

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital)

Insert Name of Hospital

(date) on

MUST MATCH DATE STATED ON FORM 7

(full name and professional address of responsible medical officer

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

examined this patient

(date) on

The first Form 11 examination date must be within 1 month prior to the expiry date of the Form 10

Later Form 11 exam dates should be within 2 months of the expiry of the previous Form

I am this patient's responsible medical officer.

One of these options should be deleted UNLESS both apply

In my opinion –
(a) this patient is suffering from *mental illness / *severe mental impairment
of a nature or degree which warrants his/her detention in hospital for medical treatment:
AND
(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

My opinion at (a) above is based on the following grounds: -

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

*(Delete if not applicable)

Please turn over

My opinion at (b) above is based on the following evidence:

(Have regard only to evidence-

(1) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself:

OR

(11) that the patient's judgement is so affected that he/she is, or would soon be unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(III) that the patient has behaved violently towards other persons:

OR

(IV) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves:

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate).

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed_____ Date_____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of Hospital	Insert name of Hospital.
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of responsible medical officer	Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Date of patient examination	The first Form 11 examination date must be within **1 month** prior to the expiry date of the Form 10. Subsequent Form 11 examination dates should be within **two months** of the expiry of the previous form.
Opinion of medical practitioner – (delete if not applicable)	One of the options in (a) should be deleted unless both apply.
Opinion state in (a) – (Clinical description of the patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition.

	The clinical description must describe the patient's mental condition and the patient's symptoms.
Opinion stated in (b) – (Specifying the inappropriateness of other methods)	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 11, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 12

JOINT MEDICAL REPORT FOR FIRST RENEWAL OF AUTHORITY FOR DETENTION FOR ONE YEAR

FORM 12
Mental Health
(Northern Ireland)
Order 1986
Article 13 (3)

(name and address of Responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital) **Insert Name of Hospital**

(date) on **MUST MATCH DATE STATED ON FORM 7**

(full name and professional address of first Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital he or she works in. The Name of the Trust is not required here.

(date) examined patient on

The examination date must be within 2 months prior to the expiry date of the first Form 11

I am a medical practitioner appointed for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission. I am not on the staff of the hospital in which the above named patient is detained and I have not given either the medical recommendation on which the application for assessment in relation to this patient was founded or any medical report in relation to this patient under Article 9 or 12 (1) of the order.

(full name and professional address of second Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(date) examined this patient on

I am a medical practitioner appointed for the purposes of Part II of the Order by the Commission.

In our opinion-

One of these options should be deleted UNLESS both apply

***(Delete if not applicable)**

(a) this patient is suffering from ***mental illness** ***severe mental impairment**

of a nature or degree which warrants his/her detention in hospital of medical treatment;

AND

(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

Please Turn Over

Our opinion at (a) above is base on the following grounds: -

(Give a clinical description of the patient's mental condition.)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Our opinion at (b) above is based on the following evidence: -

(Have regard only to evidence-

(i) that the patient has inflicted, or threatened or attempted to inflict serious physical harm on himself/herself;

OR

(ii) that the patient's judgement is so affected that he/she is, or would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community;

OR

(iii) that the patient has behaved violently towards other persons;

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves;

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.)

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED BY BOTH CONSULTANTS!

Signed _____ Date _____

Signed _____ Date _____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Inset name of hospital
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of **first** Medical Practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initial should be used. The doctor's address should be that of the hospital he or she works in. The name of the Trust is not required here.
Date – (patient examined on)	The examination date must be within **TWO MONTHS** prior to the expiry date of the **FIRST** Form 11.
Full name and professional address of **second** medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Date – (patient examined on)	The examination date must be within **TWO MONTHS** prior to the expiry date of the **FIRST** Form 11.

Medical Opinion – (delete if not applicable)	One of these options should be deleted unless both apply
Clinical description of patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms.
Specifying the inappropriateness of other methods of dealing with patient	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 12, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital.
Signed and dated	**MAKE SURE FORM IS SIGNED AND DATED BY BOTH CONSULTANTS.**

Contact information

Address:
Mental Health and Learning Disability Team
Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

E-mail: mhld.forms@rqia.org.uk

Telephone: 028 9051 7500 (Monday to Friday 10am – 4pm)