The Regulation and Quality Improvement Authority

Mental Health (Northern Ireland) Order 1986 Prescribed Forms (Forms 1 – 12) Guide

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 RQIA 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.

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.

Prescribed forms for use can be found on the DOH website (link below). Please note the use of these forms is mandatory and no others will be accepted.

Mental Health NI Order 1986 Prescribed forms | Department of Health

Standards and General Principles

This document provides guidance for those completing prescribed forms, describing the manner in which the forms should be completed and the information which must be recorded.
Further information regarding the completion of prescribed forms can be found in the following:

- The Mental Health (NI) Order, 1986
- The Mental Health (NI) Order, 1986, Code of Practice

The role of hospital staff in the receipt, scrutiny and completion of prescribed forms is detailed within the Code of Practice. A definition of "Responsible Authority" can be found within the MHO. The responsibility of the receiving medical and nursing staff in assuring the validity of the documentation is explicit.

The following general principles should be applied to ensure the validity of the documentation:

- **ALL** parts must be completed **LEGIBILY and IN FULL (i.e. no blank spaces, omissions or failure to delete)**
- Full names of patients and all practitioners involved - **NO** use of abbreviations or initials is permitted
- Full name and addresses of Trusts and Hospital – **NO** use of abbreviations is permitted, please ensure the correct Trust details are recorded
- Addresses **MUST** include postcodes
- Doctors status should be clearly indicated where required
- Forms **MUST** be signed and dated (and timed where required) in line with the timescales set out in the MHO
- Forms must be immediately submitted to RQIA by HSC Trusts. These may be sent electronically.
- 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 MHO that prescribed forms are forwarded to RQIA for scrutiny. Forms must be immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

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 starting with the date of the patient's admission to hospital. Amendments should be completed by the person who signed the form, ensuring that all amendments are initialed.

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. It is the responsibility of the Trust to closely scrutinise all forms prior to submission to RQIA, ensuring full completion and that all required and relevant information has been included.

The general principles for completion of all prescribed forms should be read in conjunction with the following supplementary notes to assist with completion of each specified form.

Form 1 Notes:

Application by the Nearest Relative for Admission for Assessment. It is used when a nearest relative applies for someone to be taken to hospital for a mental health assessment. A Form 1 should be completed immediately after the medical recommendation is made.

It is typically done the same day, because the assessment and conveyance to hospital must proceed without delay.

Information Required	**Guidance**
Name and address of responsible Authority	Insert **FULL LEGAL** name, address and postcode 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 are permitted. *Definition of "Responsible Authority" can be found within the MHO.*
Full name and address of applicant	The applicant's (nearest relative as defined in the MHO) **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure that the applicants address is provided in **FULL** including postcode.
Full name and address of patient	The patient's **FULL LEGAL** name, address and postcode should be recorded. No abbreviations or initials are permitted. Ensure recording of patients name and address 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	**ENSURE FORM IS SIGNED AND DATED**

Form 2 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, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name and address of applicant	The Approved Social Worker's **FULL LEGAL** name, office address and postcode should be recorded. No abbreviations or initials are permitted.
Full Name and address of patient	The patient's **FULL LEGAL** name and address should be recorded. No abbreviations or initials are permitted. Ensure recording of patients name and address is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Name of Trust	The **FULL** name and postcode of the appointing Trust of the ASW by must be recorded i.e. BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST No abbreviations are permitted.
	The following sections should be completed if the nearest relative was consulted. *Delete either (a) or (b) AND either (c) or (d) as appropriate.*
Name and address (a)	The ASW should select and complete section (a) **OR** (b), and complete the section in full. 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.
Name and address (b)	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).
(c)	If the nearest relative has **NO OBJECTION** to the application, the ASW should strike out the option at box (d).

(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 office address of Approved Social Worker	**IF REQUIRED** –Approved Social Worker's **FULL LEGAL** name, address and postcode should be recorded. **NO** abbreviations or initials are permitted.
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 complete this section. (Ensure that options A-D on previous page have been deleted). **Two options** from i,ii or iii should be deleted. 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	**ENSURE FORM IS SIGNED AND DATED**

Form 3 Notes:

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted. .
Full name and professional address of Medical practitioner	GP's **FULL LEGAL** name, address and postcode should be recorded. No abbreviations or initials are permitted. If the GP is not the patient's own 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	The patient's **FULL LEGAL** name, address and postcode should be recorded. No abbreviation or initials are permitted. Ensure recording of patients name and address 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)	The following sections must be completed, please ensure LEGIBLE text is written here; The GP must provide a clinical description of the patient's mental health condition and; The clinical description must describe the patient's mental condition and the patient's symptoms, **not** merely a diagnostic classification Please refer to relevant section in The Code of Practice.
Stated reason for Opinion (b)	The GP must provide 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. 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	**ENSURE FORM IS SIGNED AND DATED.**
Please 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 from 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 Form 1 as applicable.

Form 4 Notes:

Information Required	Guidance
Full name and address of patient	The patient's **FULL LEGAL** name, address and postcode should be recorded. No abbreviation or initials are permitted. Ensure recording of patients and address is consistent with **ALL** other forms completed.
Full name and professional address of medical practitioner	The RMO or other Part II doctor's **FULL LEGAL** name, address and postcode should be recorded. No abbreviations or initials are permitted.
Name of hospital	Insert name of hospital.
State exceptional circumstances of extension	This section must be completed, please ensure text is **LEGIBLE**
Sign and date	**ENSURE THE FORM IS SIGNED AND DATED.**

Form 5 Notes:

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name (doctor)	The doctor's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted.
Name of hospital	Insert name of hospital
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure recording of patients name is consistent with **ALL** other forms completed.
Reasons why voluntary treatment is no longer appropriate	An explanation stating why voluntary treatment is no longer appropriate is required. Please ensure this section is **LEGIBLE**
Signed and dated, with time stated	**ENSURE FORM IS SIGNED AND DATED. THE TIME OF COMPLETION MUST BE STATED**

Form 6 Notes:

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here. i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure recording of patients name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Full name (nurse)	The nurse's **FULL LEGAL** name is required. No abbreviations or initials are permitted.
Signed and dated, with time stated	**ENSURE FORM IS SIGNED AND DATED. THE TIME OF COMPLETION MUST BE STATED**

Form 7 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, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name and professional address of first Medical Practitioner	The doctors **FULL LEGAL** should be recorded. No abbreviation or initials are permitted. 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	The patient's **FULL LEGAL** name and address should be recorded. No abbreviation or initials are permitted. Ensure recording of patients name and address is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital
Date	The date recorded here becomes the patient's '**DATE OF ADMISSION'** for the duration of the patient's detention period. This date must be consistent across **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	Please ensure **LEGIBLE** text, and a clinical description of the patient's mental condition is provided. 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	**ENSURE FORM IS SIGNED AND DATED. THE TIME OF COMPLETION MUST BE STATED.**

Form 8 Notes:

This form should be completed by the Medical Practitioner **within 48 hours** 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, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted Ensure recording of patients 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	The RMO or other Part II doctor's **FULL** legal name, address and postcode should be recorded. No abbreviations or initials are permitted.
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. The following sections MUST be completed:
Status of medical practitioner	The medical practitioner **MUST** confirm by deleting as appropriate if they are the RMO or a practitioner appointed for the purposes of Part II of the Order
Status of patient	The medical practitioner **MUST** delete as appropriate the relevant option as to indicate the status of the patient
Clinical description of patients mental health condition	Please ensure **LEGIBLE** text, and a clinical description of the patient's mental condition is provided. 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	**ENSURE FORM IS SIGNED AND DATED.**

Form 9 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, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** should be recorded. No abbreviations or initials are permitted. Ensure recording of patients 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	The doctor's **FULL LEGAL** should be recorded. No abbreviations or initials are permitted. 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 – counting the date of the Form 7 as Day 1.
Declaration of RMO status or not. – (delete if not applicable)	The consultant should indicate their status as the patient's RMO or not by deletion of one of the options

Clinical description of the patient's mental condition	Please ensure **LEGIBLE** text, and a clinical description of the patient's mental condition is provided. 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	**ENSURE FORM IS SIGNED AND DATED.**

Form 10 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, POSTCODE MUST BE INCLUDED	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure recording of patients 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	The doctor's **FULL LEGAL** name should be recorded. No abbreviation or initials are permitted. The doctor's address including postcode 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 **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.
	The following sections must be completed:
Opinion of medical practitioner – (delete if not appropriate)	**PART (a)** **UNLESS** both options apply - **ONE** should be deleted

Opinion stated in (a) – clinical description of patients mental condition	Please ensure LEGIBLE text and a clinical description of the patient's mental condition is provided. The clinical description must describe the patient's mental condition and the patient's symptoms.
Opinion stated in (b) – evidence to support grounds for detention	**PART (b) -** the medical practitioner **MUST** delete ALL options I-IV which do not apply. Please ensure **LEGIBLE** text and all supplementary evidence to support selected options has been recorded. 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.
Signed and dated	**ENSURE FORM IS SIGNED AND DATED.**

Form 11 Notes:

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure recording of patients 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	The doctor's FULL LEGAL name should be recorded. No abbreviations or initials are permitted. The doctor's address and postcode 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)	**UNLESS** both apply **- ONE** of the options in (a) should be deleted
Opinion state in (a) – (Clinical description of the patients mental condition	Please ensure **LEGIBLE** text and a clinical description of the patient's mental condition is provided. 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)	Please ensure **LEGIBLE** text and evidence of the patient's mental condition is recorded. 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	**ENSURE FORM IS SIGNED AND DATED.**

Form 12 Notes:

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name, address and postcode of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations are permitted.
Full name of patient	The patient's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. Ensure recording of patients 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	The doctor's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. The doctor's address and postcode 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	The doctor's **FULL LEGAL** name should be recorded. No abbreviations or initials are permitted. 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)	**UNLESS** both apply – **ONE** of these options should be deleted.
Clinical description of patients mental condition	Please ensure **LEGIBLE** text and a clinical description of the patient's mental condition is provided. 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	Please ensure **LEGIBLE** text and evidence of the patient's mental condition is recorded. 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	**ENSURE FORM IS SIGNED AND DATED BY BOTH CONSULTANTS.**

Contact information

Address:

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