ANNEXURES

MHCA 01

DEPARTMENT OF HEALTH

EMERGENCY ADMISSION OR TREATMENT WITHOUT CONSENT

REPORT TO MENTAL HEALTH REVIEW BOARD

[Section 9(2) of the Act]

Surname of user ....

First name(s) of user ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Occupation .... Marital status: S M D W

Residential address: ....

....

....

....

....

Date of admission of person for emergency care without their consent ....

Time of admission of person for emergency care without their consent ....

Name of health establishment ....

Reason for admission without consent:

Based on_my/practitioners at this health establishment's assessment, any delay in providing care, treatment and rehabilitation services / admission may, due to mental illness, result in:

(a) the death or irreversible harm to the user

Reasons for this assessment (including mental health status and behavioural reasons) ....

....

....

(b) the user inflicting serious harm to him/herself or others
Reasons for this assessment (including mental health status and behavioural reasons) ……………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

(c) the user causing serious damage to or loss of property belonging to him/herself or to others
Reasons for this assessment (including mental health status and behavioural reasons) ……………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

I ………………………………………………………… (name of mental health care practitioner) hereby declare that I have personally assessed …………………………………………………… ………….. (name of mental health care user) at …………………………………………………… ………………..(name of health establishment) on …………………………………… (date).

………………………………..
Signature

Outcome of assessment within 24 hours -

(a) An application for involuntary care, treatment and rehabilitation was made
Date of application ………………………………… Time of application…………………
(b) The user agreed to voluntary care, treatment and rehabilitation.
(c) The user was discharged.

Print initials and surname………………………………………………………………………….

Signature: …………………………………………………………
(health care provider or head of health establishment)

Date: ………………………………………..

MHCA 02

DEPARTMENT OF HEALTH

REPORT ON EXPLOITATION, PHYSICAL OR OTHER ABUSE, NEGLECT OR DEGRADING TREATMENT OF A MENTAL HEALTH CARE USER
[Section 11(2) of the Act]

I ....
(name)
....
.... (address)

hereby declare that I have witnessed exploitation, physical or other abuse, neglect or degrading treatment of the following mental health care user:

(where known)
Surname of user ....
Date of birth .... or estimated age ....
Gender: Male ☐ Female ☐
Occupation .... Marital status: S M D W
Residential address: ....
....
....
....
....

Name of health establishment or other place where exploitation, physical or other abuse, neglect or degrading treatment occurred ....
Address: ....
....
....
....
....

2

Description of exploitation, physical or other abuse, neglect or degrading treatment:

....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....

Print initials and surname...

Signature: ....

(person who witnessed abuse)

Date: ....

DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 03

DEPARTMENT OF HEALTH

DISCHARGE REPORT

[Section 16 or 56 of the Act]

Full name ....

ID Number: ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Is hereby discharged from ....

(name of institution)

on .... (date of discharge)

Comments:

....

....

....

....

....

....

....

....

....

....

....

Print initials and surname...

Signature: ....

(head of health establishment)

Date: ....

[Copy to Review Board, head of prison and head of national department, as applicable]

DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 04

DEPARTMENT OF HEALTH

APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Section 27(1) or 33(1) of the Act]

I hereby apply for assisted care or involuntary care for:

Surname of user ....

First name(s) of user ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Occupation .... Marital status: S M D W

Residential address: ....

....

....

....

....

Surname of applicant ....

First name(s) of applicant ....

Date of birth of applicant .... (must be over 18 years of age)

Residential address: ....

....

....

....

....

Relationship between applicant and mental health care user: (mark with a cross)

Spouse ☐ Next of kin ☐ Partner ☐ Associate ☐

Guardian ☐ Health care provider ☐ Parent ☐

(If user is under 18 this application must be made by the parent or guardian)

2

I last saw the user on ...., ... at ....
(date) (time) (place)

(The applicant must have seen the user within seven days of making this application)

Where the applicant is the health care provider:

If the spouse, next of kin, partner, associate, parent or guardian is unwilling to make the application, state the reasons why: ....
....
....
....
....

If the spouse, next of kin, partner, associate, parent or guardian is incapable or not available to make the application, state the steps that have been taken to locate them:
....
....
....
....
....

I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons: ....
....
....
....
....

and believe that assisted- or involuntary care, treatment and rehabilitation is needed because
....
....
....
....
....

3

In the case of an application for involuntary care:

I further give reasons which show that the person is so ill that he / she will not accept treatment as a voluntary mental health care user or cannot be admitted as an assisted mental health care user

....

....

....

....

....

I also attach the following information in support of my application (if available)

- Medical certificates
- History of past mental illness / intellectual disability
- Other: ....
  ....

Print initials and surname...

Signature: ....
(Applicant)

Date: ....

Place: ....

<u>Note: Applicant must sign under oath</u>

MHCA 05

DEPARTMENT OF HEALTH

EXAMINATION AND FINDINGS OF MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Sections 27(5) and 33(5) of the Act]

Surname of user ....

First name(s) of user ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Occupation .... Marital status: S M D W

Residential address: ....

....

....

....

....

Date of examination: .... Place of examination: ....

Category of designated mental health care practitioner: ....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

....

....

....

....

(a) Are there signs of injuries? Yes ☐ No ☐

(b) Are there signs of communicable diseases? Yes ☐ No ☐

If the answer to (b) or (c) is Yes, give further particulars:

....

....

2

Information on user received from other person(s) or family (state names and contact details)

....

....

....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

....

....

....

Mental health status of the user at the time of the present examination:

....

....

....

Type of illness (provisional diagnosis):

....

....

....

In my opinion the above-mentioned user

Has homicidal tendencies	Yes ☐	No ☐
Has suicidal tendencies	Yes ☐	No ☐
Is dangerous	Yes ☐	No ☐

Recommendation to head of health establishment – application for assisted care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ☐ No ☐

The user is suffering from a mental illness / severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for their own health and safety or the health and safety of others Yes ☐ No ☐

If Yes, this should be on an inpatient or outpatient basis: Inpatient ☐ Outpatient ☐

3

Give reasons:

....

....

Recommendation to head of health establishment – application for involuntary care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ☐ No ☐

The user is willing to receive care, treatment and rehabilitation services Yes ☐ No ☐

In my view, the user is likely to inflict serious harm on him / herself or others Yes ☐ No ☐

In my view, care, treatment and rehabilitation is necessary for the user's financial interests and reputation Yes ☐ No ☐

The user should receive involuntary care, treatment and rehabilitation Yes ☐ No ☐

If No, would you recommend that the user receive assisted care? Yes ☐ No ☐

I .... (name of mental health care practitioner) hereby declare that I have personally assessed .... (name of mental health care user) at ....(name of health establishment) on .... (date).

....

Signature

Date: ....

Place: ....

MHCA 06

DEPARTMENT OF HEALTH

72-HOUR ASSESSMENT AND FINDINGS OF MEDICAL PRACTITIONER OR MENTAL HEALTH CARE PRACTITIONER AFTER HEAD OF HEALTH ESTABLISHMENT HAS GRANTED APPLICATION FOR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Section 34(1) of the Act]

Surname of user ....

First name(s) of user ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Occupation .... Marital status: S M D W

Residential address: ....
....
....
....
....

Date of beginning of 72-hour assessment: ....

Place of assessment: ....

Category of designated mental health care practitioner for example "nurse", "psychologist" or "medical practitioner": ....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

....
....
....

(a) Are there signs of injuries? Yes ☐ No ☐

(b) Are there signs of communicable diseases? Yes ☐ No ☐

If the answer to (b) or (c) is Yes, give further particulars:

....

....

....

....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

....

....

....

Mental health status of the user at the time of the present assessment:

....

....

....

Type of illness (provisional diagnosis):

....

....

....

In my opinion the above-mentioned user

Has homicidal tendencies	Yes	☐	No	☐
Has suicidal tendencies	Yes	☐	No	☐
Is dangerous	Yes	☐	No	☐

"If "No' to all the above-mentioned questions, the following recommendation and reason(s) therefore are as follows:"

<u>Recommendation to head of health establishment – application for assisted care</u>

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ☐ No ☐

The user is suffering from a mental illness / severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for their own health and

3

safety or the health and safety of others Yes ☐ No ☐

If Yes, this should be on an inpatient or outpatient basis: Inpatient ☐ Outpatient ☐

Give reasons:

……

……

Recommendation to head of health establishment – application for involuntary care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ☐ No ☐

The user is willing to receive care, treatment and rehabilitation services Yes ☐ No ☐

In my view, the user is likely to inflict serious harm on him / herself or others Yes ☐ No ☐

In my view, care, treatment and rehabilitation is necessary for the user's financial interests and reputation Yes ☐ No ☐

The user should receive involuntary care, treatment and rehabilitation Yes ☐ No ☐

If Yes, should this use receive involuntary outpatient care, treatment and rehabilitation Yes ☐ No ☐

If No, would you recommend that the user receive assisted care? Yes ☐ No ☐

Print initials and surname…………………………………………………………………………

Signature: ……………………………………………………………

(mental health care practitioner / medical practitioner)

Date: ………………………………………

Place: ………………………………………

MHCA 07

DEPARTMENT OF HEALTH

NOTICE BY HEAD OF HEALTH ESTABLISHMENT ON WHETHER TO PROVIDE ASSISTED- OR INVOLUNTARY INPATIENT CARE, TREATMENT AND REHABILITATION
[Sections 27(9), 28(1) and 33(8) of the Act]

I .... hereby consent / do not consent
(name of head of health establishment)
to the inpatient assisted care, treatment and rehabilitation / involuntary care, treatment and rehabilitation* of ....
(name of user)

The findings of two mental health care practitioners concur that the user –

(a) should / should not receive assisted care, treatment and rehabilitation services as an outpatient / inpatient; or

(b) must / must not receive involuntary care, treatment and rehabilitation services

I am satisfied / not satisfied, that the restrictions and instructions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

The reasons for consenting / not consenting are as follows:

....
....
....

Print initials and surname...

Signature: ....
(head of health establishment)
Date: ....
Place: ....

* Delete what is not applicable

[Copy to applicant, mental health care user and Review Board]

MHCA 08

DEPARTMENT OF HEALTH

NOTICE BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD REQUESTING APPROVAL FOR FURTHER INVOLUNTARY CARE, TREATMENT AND REHABILITATION ON AN INPATIENT BASIS [Section 34(3)(c)(ii) of the Act]

I. .... hereby request

(name of head of health establishment)

approval from the Review Board for further involuntary care, treatment and rehabilitation on an inpatient basis of ....

(name of user)

The findings of the mental health care practitioner and medical practitioner are that the user requires further involuntary care, treatment and rehabilitation.

I am satisfied / not satisfied that the restrictions and intrusions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

Attached hereto please find –

(a) a copy of the application to obtain involuntary care, treatment and rehabilitation [MHCA 04];

(b) a copy of the notice given in terms of section 33(8) [MHCA 07]; and

(c) a copy of the assessment findings [MHCA 06].

The basis of this request for further involuntary care, treatment and rehabilitation on an inpatient basis is ....

....

....

....

Signature: ....

(head of health establishment)

Date: ....

Place: ....

"(Copy (excluding attachments) to applicant)"

MHCA 09

DEPARTMENT OF HEALTH

NOTICE BY HEAD OF HEALTH ESTABLISHMENT AFTER 72-HOUR ASSESSMENT PERIOD INFORMING REVIEW BOARD THAT MENTAL HEALTH CARE USER WARRANTS FURTHER INVOLUNTARY CARE, TREATMENT AND REHABILITATION ON AN OUTPATIENT BASIS

[Section 34(3)(b) of the Act]

I .... hereby inform

(name of head of health establishment)

the Review Board that ....

(name of user)

requires further involuntary care, treatment and rehabilitation on an outpatient basis.

I am satisfied / not satisfied that the restrictions and intrusions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

Signature: ....

(head of health establishment)

Date: ....

Place: ....

[Copy to mental health care user and Review Board]

MHCA 10

DEPARTMENT OF HEALTH

TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER – SCHEDULE OF CONDITIONS RELATING TO HIS OR HER OUTPATIENT CARE, TREATMENT AND REHABILITATION

[Sections 34(3)(b) or (5) of the Act]

Surname of user ....

First name(s) of user ....

Date of birth .... or estimated age ....

Gender: Male ☐ Female ☐

Occupation .... Marital status: S M D W

Residential address: ....

....

....

....

....

Name of custodian into whose charge the user is discharged: ....

....

Address of custodian:..

....

....

....

....

The user's mental health status will be monitored and reviewed at ....

.... (name of health establishment)

The user is to present him / herself to this health establishment every .... weeks / months to be monitored and have his or her mental health status reviewed.

Name of health establishment(s) where involuntary mental health care, treatment and rehabilitation will be provided on an outpatient basis if different from preceding health establishment: ....

Conditions of behaviour which must be adhered to by the user:

....

....

....

....

....

Name of psychiatric hospital / care and rehabilitation centre where the user is to be admitted if he / she relapses to the extent of being a danger to him / herself or others if he / she remains an involuntary outpatient, or to which he / she is to be admitted if the conditions of outpatient care are violated ....

(name of health establishment)

Print initials and surname...

Signature: ....

(head of health establishment)

Date: ....

Place: ....

Signature of user: ....

(understand and accept the stipulated conditions)

Signature of custodian: ....

(understand and accept the stipulated conditions)

[Copy to Review Board, user, custodian and head of health establishment to whom user was referred on outpatient basis]