COMMUNITY TREATMENT ORDER
- LEVEL 1 -
(MR90B)

Hospital: ……..

Affix patient identification label in this box or fill in details

UR No: ……..

Surname: ……

Given Name: ……..

Second Given Name: ……

D.O.B: ……. Sex: ……..

Mental Health Act 2009—Sections 10, 11, 12

1. PATIENT DEMOGRAPHIC DETAILS

Address:……..

Suburb:…….. Postcode: ____ ____ ____ ____

2. EXAMINATION OF PATIENT

The above named patient was examined on:

___ ___ / ___ ___ / 2 0 ___ ___ at ___ ___:___ ___ am pm

Location:

Emergency department	☐	Community mental health service	☐
GP practice	☐	Residential address (own)	☐
Ward *(specify to the right)*	☐	……..	
Residential address (other) *(specify below)*	☐	Other *(specify below)*	☐

Please specify for 'other': ……

Mode:

Face to face	☐	Videoconference	☐

3. COMMUNITY TREATMENT ORDER (Medical Practitioner or Authorised Health Professional)

NOTE: *A medical practitioner or authorised health professional making an order MUST arrange for examination by a psychiatrist or authorised medical practitioner to occur within 24 hours or as soon as practicable thereafter.*

I have examined the above named patient, and it appears/ I am satisfied (please indicate) that the following criteria for making the **Level 1 Community Treatment Order** in respect to the above named person are fulfilled:

1. The person has a mental illness; **and**
2. Because of the mental illness, the person requires treatment for their own protection from harm (including harm involved in the continuation or deterioration of their condition) or for the protection of others from harm; **and**
3. There are facilities and services available for appropriate treatment of the illness; **and**
4. There is no less restrictive means than a **Community Treatment Order** of ensuring appropriate treatment of the person's illness.
   NOTE: *Consideration must be given , amongst other things, as to whether the person could receive all treatment of the illness necessary for the protection of the person and others on a voluntary basis.*

I therefore order that the person be treated in the community in accordance with this order

This order expires: ___ ___ / ___ ___ / 2 0 ___ ___ at 2pm

*(Expiry must be 2pm on a business day not later than 28 days after the day on which it was **made**, unless varied or revoked)*

4. DETAILS OF HEALTH PROFESSIONAL MAKING ORDER

Full name (*Please print*):	Psychiatrist ☐ Authorised Health Professional ☐ Medical Practitioner ☐ Authorised Medical Practitioner ☐ Chief Psychiatrist ☐	
Signature	Date ___ ___ / ___ ___ / 2 0 ___ ___	Time ___ ___:___ am pm
Health service/agency (*Please print*):		

Please turn over—continued over the page

Please use black ballpoint pen when completing this form

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(MR90B)

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Surname: ……

Given Name: ……..

Second Given Name: .....

D.O.B: ……... Sex: ……..

5. NOTIFICATION OF ORDER

Notification of the making of a **Level 1 Community Treatment Order** has been sent to the Guardianship Board and the Chief Psychiatrist.

Full name (*Please print*):	Designation (*Please print*):	
Signature	Date ___ ___ / ___ ___ / 2 0 ___ ___	Time ___ ___:___ ___ am pm
Health service/agency (*Please print*):		

6. COPIES OF THE ORDER AND STATEMENT OF RIGHTS

The patient must be informed that they are subject to an order as soon as it is appropriate to do so.

In accordance with s12(1) to (4), (6) of the Act:

A copy of this form must be provided to the patient as soon as it is appropriate to do so.

A copy of the Statement of Rights for this form must be provided to the patient as soon as it is appropriate to do so. *(If the patient is unable to read or comprehend the Statement of Rights, any practical steps must be taken to convey the information to the patient.)*

A copy of this form and the Statement of Rights for this form must be provided to a guardian, medical agent, relative, carer or friend of the patient if it is appropriate to do so.