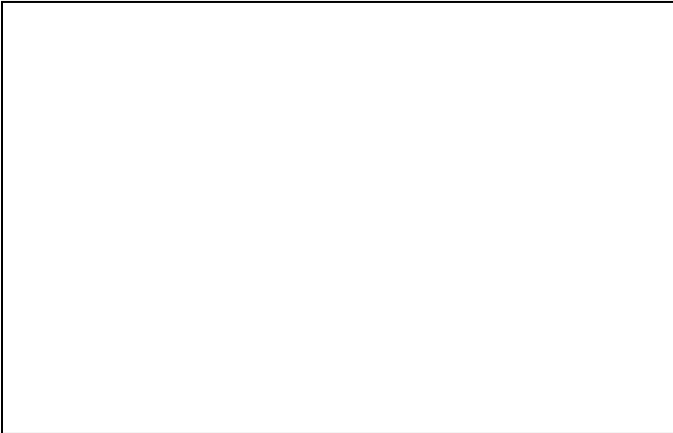




Department of Health & Community Services
Mental Health Care and Treatment Act



PLEASE PRINT LEGIBLY

COPY: Original Patient Patient Representative Administrator

Application / Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board

Section 1. Application for Review

1. This application is being made on behalf of:

Name: _____
(print name of involuntary patient or person subject to CTO)

Address: _____

Phone: _____

2. Other contacts:

	Name	Address	Phone
Patient Representative:	_____		

Social Worker: _____

Psychiatrist: _____

Rights Advisor: _____

3. This Application is for: (Check one Box)

- A review of the issuance of the certificate of involuntary admission
- A review of the issuance of the certificate of renewal
- A review of the issuance of the community treatment order
- A review of the renewal of the community treatment order
- An automatic review pursuant to Section 33 of the issuance of the certificate of renewal
- An automatic review pursuant to Section 53(3) of the renewal of the community treatment order
- A review of the denial of a right as set out in Section 11 or 12 of the *Mental Health Care and Treatment Act*

4. The date on the certificate or CTO is:

5. Please describe what you want the Review Board to do and why:_____

Applicant requests a copy of this application be forwarded to Legal Aid

Signature of Person Making Application

Date

Section 2. Withdrawal of Application for Review

Signature of Person Withdrawing Application

Date

Regional health authorities acknowledge and respect the privacy of individuals. This personal information is being collected under the Authority of Sections 32 and 33 of the *Personal Health Information Act*, and will be used for plan of care. Please direct any questions about this collection to the Privacy Officer within your region.