MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **SPOUSE* OR CIVIL PARTNER* OR RELATIVE*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Subject to Section 9(8)

Revised July 2019

**FORM 1**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**



**1. Full name of person to be admitted to an Approved Centre**

**2. Full address of person to be admitted to an Approved Centre**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** **M** ☐ **F** ☐

**4. Applicant's full name**

**First name:** **Surname:**

**5. Applicant's full address**

**Eircode:**

**6. Applicant's telephone number**

**I am the person's:**

**7. State relationship**

**I am applying for a recommendation for the involuntary admission of the above named person because:**

**8. State reason for making application**

**9. Circumstances in which application is made**

**10. Name and address of Approved Centre for admission**

**A person shall not make an application unless he or she has observed the person who is the subject of the application not more than 48 hours before the date of the making of the application.**

**I last observed the person on:**

**11. Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

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APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **SPOUSE* OR CIVIL PARTNER* OR RELATIVE*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Subject to Section 9(8)

**Revised July 2019**

**FORM 1**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**12. Previous refusal:** **Has there been a previous refusal?** **Yes** ☐ **No** ☐

**13. Date of refusal:** ☐☐/☐☐/☐☐☐☐

**14. Circumstances pertaining to the refusal**

**15. Name of doctor who refused application**

**Please note it is an offence not to disclose all information that you are aware of that relates to any previous applications for involuntary admission and their refusal.**

**16. To the best of my knowledge and belief I am not disqualified from making this application for reasons set out in Section 9(2) of the Mental Health Acts 2001 to 2018.**

**Signature of the applicant:**

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)



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Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **AUTHORISED OFFICER*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Subject to Section 9(8)

Revised July 2019

**FORM 2**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of person to be admitted to an Approved Centre**

**2. Full address of person to be admitted to an Approved Centre**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**4. Applicant's full name**

**First name:** **Surname:**

**5. Applicant's full professional address**

**Eircode:**

**6. Applicant's telephone number**

**I am applying for a recommendation for the involuntary admission of the above named person because:**

**7. State reason for making application**

**8. Circumstances in which application is made**

**9. Name and address of Approved Centre for admission**

**A person shall not make an application unless he or she has observed the person who is the subject of the application not more than 48 hours before the date of the making of the application.**

**I last observed the person on:**

**10. Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐



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Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **AUTHORISED OFFICER*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Subject to Section 9(8)

Revised July 2019

**FORM 2**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**11. Previous refusal:** **Has there been a previous refusal?** **Yes** ☐ **No** ☐

**12. Date of refusal:** ☐☐/☐☐/☐☐☐☐

**13. Circumstances pertaining to the refusal**

**14. Name of doctor who refused application**

**Please note it is an offence not to disclose all information that you are aware of that relates to any previous applications for involuntary admission and their refusal.**

**15. To the best of my knowledge and belief I am not disqualified from making this application for reasons set out in Section 9(2) of the Mental Health Acts 2001 to 2018.**

**Signature of Authorised Officer:**

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
(24 hour clock e.g. 2:41pm is written as 14:41)



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MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY A **MEMBER OF AN GARDA SÍOCHÁNA** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

Revised July 2019

**FORM 3**

Mental Health Acts 2001 to 2018

**Section 9 OR 12**

**PLEASE COMPLETE IN BLOCK CAPITALS**



**1. This application is made pursuant to:** Section 9 ☐ OR Section 12 ☐

**2. Full name of person to be admitted to an Approved Centre**

**3. Full address of person to be admitted to an Approved Centre**

Eircode:

**4. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ Age: _____ Gender: M ☐ F ☐

**5. Applicant's full name** First name: Surname:

**6. Applicant's telephone number**

**7. State any connection of applicant with person**

**8. State reason for making application**

I am applying for a recommendation for the involuntary admission of the above named person because:

**9. Circumstances in which application is made**

**10. Name and address of Approved Centre for admission**

**11. Name and address of Garda Station**

I am a member of An Garda Síochána based at:

**A person shall not make an application unless he or she has observed the person who is the subject of the application not more than 48 hours before the date of the making of the application.**

**12. Date:** ☐☐/☐☐/☐☐☐☐ I last observed the person on:

Time: ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

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MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY A **MEMBER OF AN GARDA SÍOCHÁNA** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

Revised July 2019

**FORM 3**

Mental Health Acts 2001 to 2018

**Section 9 OR 12**

**PLEASE COMPLETE IN BLOCK CAPITALS**



**13. Taken into custody:** Yes ☐ No ☐

**14. Place of custody:**

**15. Previous refusal:** Has there been a previous refusal? Yes ☐ No ☐

**16. Date of refusal:** ☐☐/☐☐/☐☐☐☐

**17. Circumstances pertaining to the refusal**

**18. Name of doctor who refused application**

**Please note it is an offence not to disclose all information that you are aware of that relates to any previous applications for involuntary admission and their refusal.**

**19.** **To the best of my knowledge and belief I am not disqualified from making this application for reasons set out in Section 9(2) of the Mental Health Acts 2001 to 2018.**

**Signature of Garda:**

**Garda Number:**

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

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MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **ANY OTHER PERSON*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Other than a Spouse / Civil Partner / Relative / Authorised Officer or member of An Garda Síochána

Revised July 2019

**FORM 4**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of person to be admitted to an Approved Centre**

**2. Full address of person to be admitted to an Approved Centre**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**4. Applicant's full name** **First name:** **Surname:**

**5. Applicant's full address**

**Eircode:**

**6. Applicant's telephone number**

**7. State any connection of applicant with person**

**I am applying for a recommendation for the involuntary admission of the above named person because:**

**8. State reason for making an application**

**9. Circumstances in which the application is made**

**10. Name and address of Approved Centre for admission**

**A person shall not make an application unless he or she has observed the person who is the subject of the application not more than 48 hours before the date of the making of the application.**

**I last observed the person on:**

**11. Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐

**(24 hour clock e.g. 2:41pm is written as 14:41)**



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MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

# APPLICATION (TO A REGISTERED MEDICAL PRACTITIONER) BY **ANY OTHER PERSON*** FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)

*Other than a Spouse / Civil Partner / Relative / Authorised Officer or member of An Garda Síochána

Revised July 2019

**FORM 4**

Mental Health Acts 2001 to 2018

**Section 9**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**12. Previous refusal:** **Has there been a previous refusal?** **Yes** ☐ **No** ☐

**13. Date of refusal** ☐☐/☐☐/☐☐☐☐

**14. Circumstances pertaining to the refusal**

**15. Name of doctor who refused application**

**Please note it is an offence not to disclose all information that you are aware of that relates to any previous applications for involuntary admission and their refusal.**

**16.** **To the best of my knowledge and belief I am not disqualified from making this application for reasons set out in Section 9(2) of the Mental Health Acts 2001 to 2018.**

**Signature of the applicant:** _____

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)



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MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

# RECOMMENDATION
(BY A REGISTERED MEDICAL PRACTITIONER)
FOR INVOLUNTARY ADMISSION OF AN ADULT
(TO AN APPROVED CENTRE)

Revised July 2019

**FORM 5**

Mental Health Acts 2001 to 2018
**Section 10**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of person the subject of recommendation**

**2. Full address of person the subject of recommendation**

**Eircode:**

**3. Date of birth OR age**
(if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** **M** ☐ **F** ☐

**4. Full name of Registered Medical Practitioner**

**5. Professional address of Registered Medical Practitioner**

**6. I am the person's General Medical Practitioner** **Yes** ☐ **No** ☐

**7. Name and address of Approved Centre for admission**

**8. Name of Applicant**

**I last examined the person on:**

**9. Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**which was within 24 hours of receipt of the application for involuntary admission which was made on:**

☐☐/☐☐/☐☐☐☐

**10. In my opinion this person is suffering from a mental disorder where:**

**(a)** because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, ☐

**OR**

**(b) (i)** because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, ☐

**AND**

**(ii)** the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

**OR**
**(a) (as above) and (b) (as above).** ☐



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Coimisiún Meabhair-Shláinte | Mental Health Commission

# RECOMMENDATION
(BY A REGISTERED MEDICAL PRACTITIONER)
FOR INVOLUNTARY ADMISSION OF AN ADULT
(TO AN APPROVED CENTRE)

Revised July 2019

**FORM 5**

Mental Health Acts 2001 to 2018
**Section 10**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**My opinion above is based on the following grounds:**

**11. Give clinical description of the person's mental disorder**

**12.** **I have informed the above named person of the purpose of the examination:** **Yes** ☐ **No** ☐

**Where "No" is indicated, I confirm that such information has been withheld because the provision of such information would be prejudicial to the person's mental health or well-being or emotional condition.**

**13.** **I am not a person disqualified from making a recommendation for reasons set out in Section 10(3) of the Mental Health Acts 2001 to 2018.**

**14.** **I shall give a copy of this Form to the applicant as per Section 10(4) of the Mental Health Acts 2001 to 2018.**

**Signature of Registered Medical Practitioner** _____

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
(24 hour clock e.g. 2:41pm is written as 14:41)

# ADMISSION ORDER

Revised July 2019

**FORM 6**

Mental Health Acts 2001 to 2018

**Sections 14 & 15**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of person the subject of recommendation**

**2. Full address of person the subject of recommendation**

**Eircode:**

**3. Date of birth OR Age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**4. Name and address of Approved Centre**

**5. Date and time of person's arrival in Approved Centre** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**6. I,** _____ **(Consultant Psychiatrist)** **(Print name)**

**examined the person on:**

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**7. In my opinion this patient continues to suffer from a mental disorder where:**

**(a)** because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, ☐

**OR**

**(b) (i)** because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, ☐

**AND**

**(ii)** the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

**OR**

**(a) (as above) and (b) (as above).** ☐



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# ADMISSION ORDER

Revised July 2019

**FORM 6**

Mental Health Acts 2001 to 2018

**Sections 14 & 15**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**My opinion above is based on the following grounds:**

**8. Give clinical description of the person's mental disorder**

**9.** **Pursuant to Section 14(1)(a) and Section 15(1) of the Mental Health Acts 2001 to 2018, I make an Admission Order for the reception, detention and treatment of the above named person for a period of 21 days from the date of the making of this Order.**

**10.** **I am not a person disqualified from making an Admission Order for reasons set out in Section 10(3) of the Mental Health Acts 2001 to 2018.**

**11.** **I shall within 24 hours of making this Order:**

- **Give to the Patient a notice in writing as required by Section 16(1)(b) and 16(2) of the Mental Health Acts 2001 to 2018;**
- **Send to the Commission a copy of the Order as required by Section 16(1)(a) of the Mental Health Acts 2001 to 2018.**

**Signed:** _____ **(Consultant Psychiatrist)**

**MCRN:** ☐☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐

(24 hour clock e.g. 2:41pm is written as 14:41)

# CERTIFICATE AND RENEWAL ORDER BY RESPONSIBLE CONSULTANT PSYCHIATRIST

Revised July 2019

FORM 7

Mental Health Acts 2001 to 2018

Section 15

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

PLEASE COMPLETE IN BLOCK CAPITALS

(Part One and Part Two must be signed)



## PART ONE: CERTIFICATE PURSUANT TO SECTION 15(4) OF THE MENTAL HEALTH ACT 2001

1. Full name of patient

2. Full address of patient

Eircode:

3. Date of birth OR Age (if date of birth not known) ☐☐/☐☐/☐☐☐☐ Age: _____ Gender: M ☐ F ☐

4. Name and address of Approved Centre

5. Date of Involuntary admission ☐☐/☐☐/☐☐☐☐

6. I, _____ (Consultant Psychiatrist) (Print name)

examined the person on:

Date: ☐☐/☐☐/☐☐☐☐ Time: ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

(within 7 days of the making of this Order).

7. In my opinion this patient continues to suffer from a mental disorder where:

(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, ☐

OR

(b) (i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, ☐

AND

(ii) the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

OR

(a) (as above) and (b) (as above). ☐

My opinion above is based on the following grounds:

8. Give clinical description of the person's mental disorder

Signed: _____ (Responsible Consultant Psychiatrist)

MCRN: ☐☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Time: ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

# CERTIFICATE AND RENEWAL ORDER BY RESPONSIBLE CONSULTANT PSYCHIATRIST

Revised July 2019

FORM 7

Mental Health Acts 2001 to 2018

Section 15

PLEASE COMPLETE IN BLOCK CAPITALS

## PART TWO — RENEWAL ORDER

9. Full name of patient

10. * Pursuant to Section 15(2) of the Mental Health Act 2001, the period referred to in Section 15(1) of the Act of 2001 is hereby extended for a further period ending on ☐☐/☐☐/☐☐☐☐ [insert date] (being a period not exceeding 3 months) beginning upon the expiration of the Order on foot of which the reception, detention and treatment of the patient is currently authorised.

* Pursuant to Section 15(3) of the Mental Health Act 2001 (as amended), the period referred to in Section 15(1) of the Act of 2001 is hereby extended for a further period ending on ☐☐/☐☐/☐☐☐☐ [insert date] (being a period not exceeding 6 months) beginning upon the expiration of the Order on foot of which the reception, detention and treatment of the patient is currently authorised.

* (Delete where appropriate)

11. I shall within 24 hours of making this order:

- Give to the patient a notice in writing as required by Section 16(1)(b) and 16(2) of the Mental Health Acts 2001 to 2018
- Send to the Commission a copy of the Order as required by Section 16(1)(a) of the Mental Health Acts 2001 to 2018

Signed: _____ (Responsible Consultant Psychiatrist)

MCRN: ☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Time: ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)



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# NOTICE OF PATIENT TRANSFER TO ANOTHER APPROVED CENTRE

(OTHER THAN THE CENTRAL MENTAL HOSPITAL)

Revised July 2019

**FORM 10**

Mental Health Acts 2001 to 2018

**Section 20**

**OR 21**

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of patient being transferred**

**2. Date of birth OR Age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**3. Name and address of Approved Centre to which patient was first admitted**

**4. Date of admission** ☐☐/☐☐/☐☐☐☐

**TRANSFER DETAILS**

**The patient is being transferred from:**

**5. Approved Centre from which the patient is being transferred** (if other than Section 3 above)

**The patient is being transferred to:**

**6. Approved Centre to which the patient is being transferred**

**7. Transfer made pursuant to:** **Section 20** ☐ **OR** **Section 21** ☐

**The following are the reasons for the transfer:**

**8. Give reasons for transfer by reference to Section 20 OR Section 21**

**9.** **The Clinical Director of the Approved Centre to where the patient is being transferred has agreed to this transfer.**

**10. Date of transfer:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

**11.** **I hereby authorise the transfer of the patient.**

**12.** **I shall give notice of this transfer to the patient and I shall give notice to the Commission.**

**Signed:** _____ **(Clinical Director)**

**Print name:** _____ **(Clinical Director)**

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

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# PROPOSAL BY THE CLINICAL DIRECTOR TO TRANSFER PATIENT TO THE CENTRAL MENTAL HOSPITAL

Revised July 2019

**FORM 11**

Mental Health Acts 2001 to 2018
**Section 21(2)**

Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS**



**1. Full name of patient being proposed for transfer**

**2. Full address of patient**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**4. Name and address of Approved Centre to which patient was admitted**

**5. Date of admission** ☐☐/☐☐/☐☐☐☐

## PROPOSAL TO TRANSFER

**6.** I hereby propose to transfer the patient.

I am of the opinion that it would benefit the above named patient to be transferred to the Central Mental Hospital for the following reasons:

**7.** Give details of how this transfer will benefit the patient and/or that it is necessary for the purpose of obtaining special treatment for such patient.

**8.** I request that the Mental Health Commission refer this proposal to a Mental Health Tribunal.

**9.** I shall give notice in writing of the making of this proposal to the patient.

**Signed:** _____ (Clinical Director)

**Print name:** _____ (Clinical Director)

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

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For information in relation to the Section of the Mental Health Act 2001 to which this form refers, please click **here**.

# NOTICE OF TRANSFER OF A PATIENT TO THE CENTRAL MENTAL HOSPITAL

Revised July 2019

**FORM 12**

Mental Health Acts 2001 to 2018

**Section 21(3)**

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS**

**Following authorisation from the Tribunal in accordance with Section 21(2)(b)(i), I, the Clinical Director, have arranged for the transfer of:**

**1. Full name of patient being transferred**

**in accordance with Part 2 of the Mental Health Acts 2001 to 2018.**

**2. Full address of patient**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** **M** ☐ **F** ☐

**4. Name and address of Approved Centre to which patient was admitted**

**5. Date of admission** ☐☐/☐☐/☐☐☐☐

**NOTICE OF TRANSFER**

**6. Date of proposal to transfer** ☐☐/☐☐/☐☐☐☐

**7. Date of Mental Health Tribunal authorising the transfer** ☐☐/☐☐/☐☐☐☐

**8. Date of transfer:** **I have arranged that the above named patient be transferred to the Central Mental Hospital on:**

☐☐/☐☐/☐☐☐☐

**9. I shall give notice in writing of this transfer to the patient and I shall give notice to the Commission.**

**Signed:** _____ **(Clinical Director)**

**Print name:** _____ **(Clinical Director)**

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)



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# CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2019

**FORM 13**

Mental Health Acts 2001 to 2018

**Sections 23 & 24**

Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS** (Part One, Part Two and Part Three must be signed)

## PART ONE

**1. Full name of person**

**2. Full address of person**

Eircode:

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**4. Name and address of Approved Centre**

**5. Date and time person indicated a wish to leave** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**6. Date and time Section 23(1) was used to detain the person** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**7. Professional who detained person pursuant to Section 23(1)** Consultant Psychiatrist ☐ OR Registered Medical Practitioner ☐ OR Registered Nurse ☐

**8. Reasons provided for detaining person pursuant to Section 23(1)**

**9.** I, _____ (Responsible Consultant Psychiatrist) (Print name)

examined this patient on:

Date: ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**10. In my opinion this patient continues to suffer from a mental disorder where:**

(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, ☐

OR

(b) (i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, ☐

AND

(ii) the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

OR

(a) (as above) and (b) (as above). ☐



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# CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2019

**FORM 13**

Mental Health Acts 2001 to 2018

**Sections 23 & 24**

Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS**

## PART ONE continued

**My opinion above is based on the following reasons:**

**11. Give clinical description of the reasons for forming the opinion above**

**Signed:** _____ **(Responsible Consultant Psychiatrist)**

**Print name:** _____ **(Responsible Consultant Psychiatrist)**

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

## PART TWO - SECTION 24(2)(a) CERTIFICATE

**This certificate is to be completed by another consultant psychiatrist following referral by the consultant psychiatrist responsible for the care and treatment of the person.**

**12. Name of person**

**13. I am not a spouse or relative of the patient.**

**14. In my opinion this patient continues to suffer from a mental disorder where:**

**(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,** ☐

**OR**

**(b) (i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission,** ☐

**AND**

**(ii) the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.** ☐

**OR**

**(a) (as above) and (b) (as above).**

# CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2019

FORM 13

Mental Health Acts 2001 to 2018

**Sections 23 & 24**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**I have examined the above patient and I am of the opinion that the person is suffering from a mental disorder.**

**15. State reasons for opinion:**

**OR**

**I have examined the above patient and I am of the opinion that the person is not suffering from a mental disorder.**

**State reasons for opinion:**

**Signed:** _____ **(Consultant Psychiatrist)**

**Print name:** _____ **(Consultant Psychiatrist)**

**MCRN:** ☐☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
(24 hour clock e.g. 2:41pm is written as 14:41)

## PART THREE - ADMISSION ORDER

**16.** **A certificate has been issued under subsection 24(2)(a) by a second consultant psychiatrist. In accordance with Section 24(3) and (4) I make an admission order for the reception, detention and treatment of the above named person for a period of 21 days from the date of the making of this Order.**

**17.** **I am not a person disqualified from making this Order.**

**18.** **I shall within 24 hours of making this Order:**

- **Give to the patient a notice in writing as required by Section 16(1)(b) and 16(2) of the Mental Health Acts 2001 to 2018;**
- **Send to the Commission a copy of the Order as required by Section 16(1)(a) of the Mental Health Acts 2001 to 2018.**

**Signed:** _____ **(Responsible Consultant Psychiatrist)**

**Print name:** _____ **(Responsible Consultant Psychiatrist)**

**MCRN:** ☐☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
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# REVOCATION OF AN INVOLUNTARY ADMISSION OR RENEWAL ORDER

Revised June 2019

**FORM 14**

Mental Health Acts 2001 to 2018

**Section 28**

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

**PLEASE COMPLETE IN BLOCK CAPITALS**



**1. Full name of patient**

**2. Full address of patient**

**Eircode:**

**3. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** **Gender:** **M** ☐ **F** ☐

**4. Name and address of Approved Centre to which patient was admitted**

**5. Date of admission** ☐☐/☐☐/☐☐☐☐

**6. I examined this patient and in my opinion this patient is no longer suffering from a mental disorder as defined in the Mental Health Acts 2001 to 2018.**

**7. Date and time patient was examined** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**8. I shall give to the patient concerned and his or her legal representative a copy of this Form, as specified by the Mental Health Commission, to the effect that he or she:**

**(a) is being discharged pursuant to Section 28 of the Mental Health Act 2001,**

**AND**

**(b) is entitled to have his or her detention reviewed by a Tribunal in accordance with the provisions of Section 18 or, where such review has commenced, completed in accordance with that section if he or she so indicates by notice in writing addressed to the Mental Health Commission within 14 days of the date of his or her discharge.**

**9. I hereby revoke the relevant Admission/Renewal Order from:**

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**Signed:** _____ **(Responsible Consultant Psychiatrist)**

**Print name:** _____ **(Responsible Consultant Psychiatrist)**

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

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