## ANNEXURE

### FORM MHCA 01

**DEPARTMENT OF HEALTH**

**REPORT TO MENTAL HEALTH REVIEW BOARD ON PROVISION OF CARE, TREATMENT AND REHABILITATION WITHOUT CONSENT OR EMERGENCY ADMISSION**

*Section 9(2) of the Act*

<table>
<thead>
<tr>
<th>Surname of User</th>
<th>First name(s) of User</th>
<th>Date of birth or estimated age</th>
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**Gender:**

- [ ] Male
- [ ] Female

**Occupation:**

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<tr>
<th>Residential address</th>
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**Marital status:**

- [ ] S
- [ ] M
- [ ] D
- [ ] W

**Residential address:**

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**Date of admission:**

|                     |

**Time of admission:**

|                     |

**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).
Designation: ..........................................................................................
Contact Numbers: ........................................................................

Outcome of assessment within 24 hours-
(a) An application for involuntary or assisted care, treatment and rehabilitation was made—
Date of application ........................................ Time of application......................
(b) The User agreed to voluntary care, treatment and rehabilitation.
(c) Patient discharged as a mental health care user.

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

Signature:

(Health care provider  □ or Head of health establishment  □)

Date: .................................................................

(Submit to relevant Review Board)