# FORM MHCA 05

## DEPARTMENT OF HEALTH

**REPORT ON COMPLETION OF EXAMINATION AND FINDINGS BY MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION FOR ASSISTED OR INVOLUNTARY CARE TREATMENT AND REHABILITATION**  
*Section 27(5) or 33(5) of the Act*

### Section 1

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: .................................................................  
.................................................................  
.................................................................  
.................................................................  

### Section 2

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

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

(a) General physical health:

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

(b) Are there signs of injuries?  
Yes □  No □  

If yes, please indicated whether you believe this is as a result of abuse?  
Yes □  No □  Unsure □  

If yes, was this abuse reported/investigated?  
Yes □  No □  

(c) Are there signs of communicable diseases?  
Yes □  No □
If the answer to (b) or (c) is Yes, give further particulars:

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 3
Information on User received from other person(s) or family (state names and contact details):

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 4
Previous mental health history if known (State dates and places):

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 5
Mental health status of the User at the time of the present examination (describe symptoms or diagnostic criteria):

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 6
Type of illness (provisional diagnosis):

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 7
In my opinion the above-mentioned User—

has homicidal tendencies due to mental illness  Yes □ No □
has suicidal tendencies due to mental illness Yes □ No □
is a risk to inflicting serious harm to him/herself or others or causing serious damage to
property belong to him/her or other due to mental illness Yes □ No □

Section 8
Recommendation to head of health establishment on an application for assisted care, treatment and rehabilitation services only (do not complete section 9 of this form if section 8 is applicable)—
An application was made for assisted care, treatment and rehabilitation services □ or involuntary care □, treatment and rehabilitation services □

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services for their own health and safety or the health and safety of others? Yes □ No □

2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes □ No □

3. Is the User willing to receive care, treatment and rehabilitation services? Yes □ No □

Section 9
Recommendation to head of health establishment on an application for Involuntary care, treatment and rehabilitation services only (Do not complete section 8 of this form if section 9 is applicable)

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services? Yes □ No □

2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes □ No □

3. Does the User refuse to receive care, treatment and rehabilitation services? Yes □ No □

4. Is the User in your view, likely to inflict serious harm on him/herself or others? Yes □ No □
5. Is care, treatment and rehabilitation services, in your view necessary for the protection of the User's financial interests or reputation? □ Yes □ No

Section 10
Based on the abovementioned information my recommendation to the head of health establishment is that the User should—

1. Receive voluntary care, treatment and rehabilitation services □
2. Receive assisted in-patient care, treatment and rehabilitation services □
3. Undergo 72 hour assessment following the application for involuntary care, treatment and rehabilitation services to determine the need for further care, treatment and rehabilitation services □

Section 11
I declare that I have personally informed the mental health care User of his/her rights, including his/her right to representation including the right to legal representation and/or Legal Aid, and the right to have his/her financial interests or reputation safeguarded and his/her right to have an administrator or curator appointed.

Comment:

I ........................................................................... (name of mental health care practitioner) hereby declare that I have personally assessed ...............................................................

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

Registration number with relevant Council: ……………………..

Date: ………………………………………..

Place: ………………………………………..

This gazette is also available free online at www.gpwnline.co.za