



**Queensland
Government**

Mental Health Act 2016
Extension of Seclusion

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Mental Health Act (MHA) 2016, Sections 259, 261

- A patient may be kept in seclusion in an authorised mental health service (AMHS) for no more than 9 hours in a 24 hour period, unless approved under a reduction and elimination plan.
- With the approval of the clinical director or delegate, an authorised doctor may authorise ONE extension of seclusion for up to 12 hours to allow for the development and approval of a reduction and elimination plan.
- The Chief Psychiatrist must be immediately notified of the approval of an extension to seclusion.

1. Person's details

- Not required if label affixed in top right corner.

Surname:

Given name(s):

Residential address:

Town / Suburb:

State:

Postcode:

Date of birth:

Age:

or

Sex:

Male

Female

Intersex / Indeterminate

Not stated / unknown

2. Treating AMHS and MHA status

Name of AMHS:

MHA status: Treatment authority Forensic order Treatment support order Detained from interstate

3. Details of the patient's mental condition

- Include details of the patient's diagnosis and current treatment.

4. Reasons for no other reasonably practicable way

- Provide reasons that you believe there is no other reasonably practicable way to protect the patient or others from physical harm. Include the reason that alternative management strategies have not been or will not be sufficient.

DO NOT WRITE IN THIS BINDING MARGIN

v2.00 - 06/2020



SW741

EXTENSION OF SECLUSION



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5. Reason reduction and elimination plan has not yet been prepared

• Provide reasons that it has not been possible to prepare a reduction and elimination plan for the Chief Psychiatrist's approval.

[Large empty box for providing reasons]

6. Period of seclusion

• The time period must be no longer than 12 hours.

Hours:	Minutes:	Commencement	Date:	Time (24hr):	Cessation	Date:	Time (24hr):
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7. Previous use of seclusion

This authorisation immediately follows a previous authorisation Yes No

8. Patient care and observation

List the measures required for the health, safety and comfort of the patient:

[Large empty box for listing measures]

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Detail how the patient is to be observed continuously or at intervals of no more than 15 minutes.

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9. Ending of seclusion

I authorise a health practitioner to end the seclusion before the cessation time if the seclusion is no longer necessary. Yes No

- The health practitioner must tell the authorised doctor as soon as practicable if the practitioner ends the seclusion.

10. Authorised doctor's declaration

- A reduction and elimination plan must be prepared and application made to the Chief Psychiatrist for its approval.

I am satisfied that:

- There is no other reasonably practicable way to protect the patient or others from physical harm.
- Where relevant, the authorisation complies with a direction given by the Chief Psychiatrist.
- The authorisation complies with the Chief Psychiatrist Policy: Seclusion.
- It has not been reasonably practicable for a reduction and elimination plan to be approved.

Name:	Designation:	
Signature:	Contact number:	Date:
Address:	Town / Suburb:	Postcode:

11. Approval

- To be completed by a clinical director or delegate.
- If, in urgent circumstances, the clinical director gives initial approval via email, a copy of the email must be attached to this form. This section must be signed by the clinical director within 24 hours of the email approval.

I am satisfied that:

- There is no other reasonably practicable way to protect the patient or others from physical harm.
- Where relevant, the authorisation complies with a direction given by the Chief Psychiatrist.
- The authorisation complies with the Chief Psychiatrist Policy: Seclusion.
- It has not been reasonably practicable for a reduction and elimination plan to be approved.

Name:	Designation:	Signature:	Date:
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TO: AMHS Administrator (AMHS Administrator to forward to Chief Psychiatrist)



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12. Actual time in seclusion under this authorisation

- Complete details for each occasion patient is removed from, and returned to, seclusion under this authorisation.
- This information may be recorded on the *Return to and Release from Seclusion* form.

OUT	Removed from seclusion		
	The patient was removed from seclusion on – Date: _____ Time (24hr): _____ The authorised doctor / health practitioner who removed the patient from seclusion:		
	Name:	Signature:	Date:
IN	Returned to seclusion		
	The patient was returned to seclusion on – Date: _____ Time (24hr): _____ The authorised doctor / health practitioner who returned the patient to seclusion:		
	Name:	Signature:	Date:
OUT	Removed from seclusion		
	The patient was removed from seclusion on – Date: _____ Time (24hr): _____ The authorised doctor / health practitioner who removed the patient from seclusion:		
	Name:	Signature:	Date:
IN	Returned to seclusion		
	The patient was returned to seclusion on – Date: _____ Time (24hr): _____ The authorised doctor / health practitioner who returned the patient to seclusion:		
	Name:	Signature:	Date:
OUT	Removed from seclusion		
	The patient was removed from seclusion on – Date: _____ Time (24hr): _____ The authorised doctor / health practitioner who removed the patient from seclusion:		
	Name:	Signature:	Date:

- Authorisation revoked by authorised doctor
- The Chief Psychiatrist directed the patient be removed from seclusion

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