

	<b>Queensland</b> Government
S TOTAL	Government

Mental Health Act 2016

## Recommendation for Assessment

	(Affix identification la	bel here)		
URN:				
Family name:				
Given name(s):				
Address:				
Date of birth:		Sex: M	□ F	I

RECOMMENDATION FOR ASSESSMENT

## Mental Health Act (MHA) 2016, Sections 10, 12-14, 39-47, 64

- · A recommendation for assessment may be made by a doctor or authorised mental health practitioner who has examined the person within the preceding 7 days.
- · A recommendation for assessment is valid for 7 days after it is made.

1. Person's deta	ails					
<ul> <li>Not required if label</li> </ul>	affixed in top right corner.					
Surname:			Give	n name(s):		
Residential address:						
Town / Suburb:					State:	Postcode:
Date of birth:	Age:	Sex:			,	
	or	Male _	Female	☐ Intersex / In	determinate N	ot stated / unknown
2 Reasons for	making recommend	lation for a	seasen	nent		

• Provide reasons that you believe the treatment criteria may apply and why there appears to be no less restrictive way for the person to receive treatment and care.

The reasons you believe the person may have a mental illness:

The reasons you believe the person may not have capacity to consent to be treated for the illness:

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Address:					
Date of birth:			Sex:	□F	

Mental Health Act 2016	Family name:				
Recommendation	Given name(s):				
for Assessment	Address:				
	Date of birth:	Sex	c:	□ F	
The reasons you believe that not providing involuntary treatriction in imminent serious harm to the person or others; or ii. the person suffering serious mental or physical deterioration in the person suffering serious mental or physical deterioration in the person suffering serious mental or physical deterioration in the person suffering serious mental or physical deterioration in the person suffering serious mental or physical deterioration in the person suffering serious mental or physical deterioration in the person or others; or in the person suffering serious mental or physical deterioration in the person of the person	•	It in:			
The reason you believe that there appears to be no less resmental illness:	trictive way for the person to	receive treatment and o	are for th	e perso	n's
<ul> <li>3. Detention for purpose of making recomm</li> <li>A person may, in specified circumstances, be detained at a facility for up to one hour to allow a recommendation for as</li> <li>This section should only be completed if the doctor or authorecommendation for assessment to be made.</li> </ul>	an authorised mental health s ssessment to be made.	service (AMHS) or publi			
Details of when detention (to allow recommendation for asset be made) was commenced	essment to	Date detained:	Time det	ained (2	24hr):
Reasons for detention:					

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COUNTY.	Government

(Affix identificat	tion label he	ere)			
		Sex:	] M	F	
	(Affix identificat	(Affix identification label he	(Affix identification label here)		(Affix identification label here)  Sex:

	Recommend for Ass	ealth Act 2016 mendation sessment on when reco	ommendatio		s): essment is	made	Sex: M	_F _I
·		at an AMHS or pu			•			
5. Decla	ration							
		n within 7 days pr ed there appears t						
Name:				Desig	nation:			
Signature:			Contac	t number:		Date:	Time ma	de (24hr):
Address:				Town	/ Suburb:		Postcode	e:
TO: AMHS	Administrator							
period sta If the pers above), th If the pers made, the service en	rts.  con is at an AM e assessment p con is received assessment pe nployee must re	HS or health serveriod starts when at an AMHS or period starts when cord the date and ector health services	vice facility what the recommend bublic sector had the person first at time the person	nen the record dation is mad ealth service attends the A	nmendation for e (i.e. at the da facility after to MHS or health	or assessment is ate and time recor the recommenda	s made (see sec ded in section 5 ation for assess r the assessmer	ation 4 above). ament is
					To: 4			
Name:			Designation:		Signature:		Date:	
7. Extens	sion of asse	essment peri	od					
An authori the assess		extend the asses	ssment period fo	or not more th	an 72 hours af	ter the start time i	if necessary to c	omplete
Extension	Expiry date	Expiry time (24hr)	Extended b	y (name)	Sig	nature	Date	Time (24hr)
Ext 1								
Reasons wi	hy treatment aut	ity not made thority was not ma ment criteria do n	ade:		r			

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Mental Health Act 2016

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Family name:				
Given name(s):				
Address:				
Date of birth:		Sex: M	□ F	

There is a less restrictive way for the person to receive treatment and care (provide reasons)				
Name of AMHS or public sector health service facility:				
Name:	Designation:	Signature:	Date:	Time:
FO. AMUO A desiminate a				
TO: AMHS Administrator				