



**Queensland
 Government**

Mental Health Act 2016
**Revocation of
 Treatment Authority**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Mental Health Act (MHA) 2016, Sections 206–208

- An authorised doctor or the Chief Psychiatrist may revoke a treatment authority if the treatment criteria do not apply or there is a less restrictive way of treatment.
- An authorised doctor who is not a psychiatrist must consult with an authorised psychiatrist before revoking an authority.

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Indeterminate <input type="checkbox"/> Not stated / unknown	

2. Reasons for revocation

- The person no longer has a mental illness
- The person has capacity to consent to be treated for the mental illness
- Because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is unlikely to result in:
 - i. imminent serious harm to the person or others, or
 - ii. the person suffering serious mental or physical deterioration
- There is a less restrictive way for the person to receive treatment and care for the person's mental illness (*provide reasons*)

- Authorised mental health service (AMHS) has not been able to locate patient for 6 months (only authorised psychiatrist can revoke)

3. Revocation by authorised doctor who is not a psychiatrist

- This section only needs to be completed if the authorised doctor revoking the treatment authority is not an authorised psychiatrist.

Name of authorised psychiatrist consulted:	Date consulted:
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DO NOT WRITE IN THIS BINDING MARGIN

V1.00 - 01/2017



SW723

REVOCATION OF TREATMENT AUTHORITY



**Queensland
Government**

Mental Health Act 2016

Revocation of Treatment Authority

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

4. Authorised doctor or Chief Psychiatrist details

Name:		Designation:	
Address:			
Town / Suburb:			Postcode:
Signature:	Contact number:	Date:	Time (24hr):

**TO: AMHS Administrator
Mental Health Review Tribunal**

DO NOT WRITE IN THIS BINDING MARGIN