

Mental Health Act 2016

	(Affix identification label here)	
URN:		
Family name:		
Given name(s):		
Address:		

Limited Community Treatment (LCT) Access and Return Sex: M F I Date of birth: · This form is to be completed for each occasion of limited community treatment accessed by the patient. **TYPE OF LEAVE AUTHORISATION** DATE Time (24 hr): OUT / Time (24 hr): **DUE BACK** Health service employee name: Signature: RETURNED Time (24 hr): Health service employee name: Signature: OUT / Time (24 hr): Time (24 hr): **DUE BACK** Health service employee name: Signature: Time (24 hr): **RETURNED** Signature: Health service employee name: LIMITED COMMUNITY TREATMENT (LCT) ACCESS AND RETURN OUT / Date: Time (24 hr): **DUE BACK** Time (24 hr): Health service employee name: Signature: RETURNED Time (24 hr): Health service employee name: Signature: OUT / Time (24 hr): Time (24 hr): **DUE BACK** Signature: Health service employee name: RETURNED Time (24 hr): ... Health service employee name: Signature: OUT / Time (24 hr): ____ Time (24 hr): **DUE BACK** Health service employee name: Signature: **RETURNED** Time (24 hr): Signature: Health service employee name:

	Queensland Government
CONT	Government

Mental Health Act 2016

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Attach additional pages if required.