Queensland Government

Mental Health Act 2016

Transfer Recommendation (Classified Patient)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Mental Health Act (MHA) 2016, Sections 68(2), 74

- A *Transfer Recommendation* may be made by a doctor or authorised mental health practitioner to transport a person from a place of custody to an inpatient unit of an authorised mental health service (AMHS) for treatment and care for a mental illness.
- An *Administrator Consent* and *Custodian Consent* are also required for the transport of the person to occur.
- On admission to the inpatient unit the person becomes a classified patient.
- This form may also be used by an authorised doctor to recommend that a person who has been transported from a place of custody to an AMHS under an examination order or court examination order should remain at an AMHS for treatment and care as a classified patient.

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. MHA status

☐ Treatment authority ☐ Forensic order (mental health) ☐ Treatment support order ☐ Nil

3. Reasons for transfer

If the person is not subject to a treatment authority, forensic order (mental health) or treatment support order, provide the reasons that you are satisfied the person may have a mental illness

Provide reasons that you believe it is clinically appropriate for the person to receive treatment and care for a mental illness in an inpatient unit of an AMHS

DO NOT WRITE IN THIS BINDING MARGIN

TRANSFER RECOMMENDATION (CLASSIFIED PATIENT)

v1.00 - 01/2017

SW729

Queensland Government

Mental Health Act 2016

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Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

4. AMHS the person is to be transferred to, or remain in

Name of AMHS:	
Contact person:	Contact details:

5. Details of person recommending transfer

☐ Doctor ☐ Authorised mental health practitioner

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

TO: AMHS Administrator

DO NOT WRITE IN THIS BINDING MARGIN