



**Queensland
 Government**

Mental Health Act 2016

**Return to and
 Release from Seclusion**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

• This form is to be used to record continuation of actual time in seclusion under an **Authorisation for Seclusion** or an **Extension of Seclusion**.

DO NOT WRITE IN THIS BINDING MARGIN

RETURN TO AND RELEASE FROM SECLUSION

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

<input type="checkbox"/> Authorisation revoked by authorised doctor
<input type="checkbox"/> The Chief Psychiatrist directed the patient be removed from seclusion

