



**Queensland
Government**

Mental Health Act 2016

Application for Approval to Use Mechanical Restraint

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Mental Health Act (MHA) 2016, Sections 247, 375

- An authorised doctor may apply to the Chief Psychiatrist for approval to use mechanical restraint on:
 - particular involuntary patients in an inpatient or other unit of an authorised mental health service (AMHS); or
 - to transport an involuntary patient to, from or within an AMHS, including to move a patient within an AMHS for treatment or diagnostic tests.

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. Treating AMHS and MHA status

Name of AMHS:

MHA status: Treatment authority Forensic order Treatment support order Detained from interstate
 Other involuntary patient (transport only) – specify:

3. Details of the patient's mental condition

- Include details of the patient's diagnosis and current treatment.

4. Purpose for using mechanical restraint

DO NOT WRITE IN THIS BINDING MARGIN

V1.00 - 01/2017



SW722

APPLICATION FOR APPROVAL TO USE MECHANICAL RESTRAINT



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5. Reasons for no other reasonably practicable way

• Provide reasons that you believe there is no other reasonably practicable way to protect the patient or others from physical harm. Include the reason that alternative management strategies have not been or will not be sufficient to protect the patient or others from physical harm.

6. Proposed period of approval

• For patients in an inpatient or other unit of an AMHS, the period for which approval is sought cannot be more than 7 consecutive days.

Approval period commencement	Date:	Time (24hr):	Approval period cessation	Date:	Time (24hr):
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7. Device for which approval is sought

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8. Proposed limitations on the use of mechanical restraint

9. Details of how the patient will be continuously observed

10. Is a reduction and elimination plan attached?

• This does not apply to mechanical restraint for the purposes of transport only.

Yes No

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11. Authorised doctor details

Name:	Designation:	Signature:	Date:
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AMHS address:

Town / Suburb:	Postcode:	Contact number:
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TO: AMHS Administrator (AMHS Administrator to forward to Chief Psychiatrist)

12. Chief Psychiatrist approval

- The Chief Psychiatrist may require the authorised doctor to amend the application to include an application for approval of a reduction and elimination plan. This does not apply to mechanical restraint for the purposes of transport only.
- This approval includes:
 - the approval of the device (*MHA 2016 s243*); and
 - if not a high security unit, the approval of the AMHS to use the mechanical restraint (*MHA 2016 s246*).

- Approved as specified in the application
- Approved as specified in the application with conditions (*provide conditions below*)
- To be amended to include an application for approval of a Reduction and Elimination Plan
- Not approved (*provide reasons below*)

Conditions of approval for the use of mechanical restraint or reasons application was not approved:

Name:	Signature:	Date:	Time (24hr):
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TO: AMHS Administrator

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