Queensland Government

Mental Health Act 2016

Limited Community Treatment (LCT) Access and Return

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

- This form is to be completed for each occasion of limited community treatment accessed by the patient.

TYPE OF LEAVE	
AUTHORISATION DATE	
OUT /	Date: .... Time (24 hr): ....
DUE BACK	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:
RETURNED	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:
OUT /	Date: .... Time (24 hr): ....
DUE BACK	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:
RETURNED	Date: .... Time (24 hr): ....
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OUT /	Date: .... Time (24 hr): ....
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	Health service employee name: / Signature:
RETURNED	Date: .... Time (24 hr): ....
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OUT /	Date: .... Time (24 hr): ....
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	Health service employee name: / Signature:
RETURNED	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:
OUT /	Date: .... Time (24 hr): ....
DUE BACK	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:
RETURNED	Date: .... Time (24 hr): ....
	Health service employee name: / Signature:

Attach additional pages if required.

DO NOT WRITE IN THIS BINDING MARGIN

v1.00 - 01/2017

SW763

LIMITED COMMUNITY TREATMENT (LCT) ACCESS AND RETURN

Queensland Government

Mental Health Act 2016

Limited Community Treatment (LCT) Access and Return

(Affix identification label here)

URN:

Family name:

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