Form GU 7

Regulation 13

Mental Health Act 1983 section 21B - authority for guardianship after absence without leave for more than 28 days

PART 1

To be completed by the responsible clinician or nominated medical attendant

To

(name of guardian)

(name of responsible local social services authority if it is not the guardian)

(full name of patient) I examined

(date of examination) on

who

(date absence without leave began)

(a) was absent without leave from the place where the patient is required to reside beginning on

(delete the phrase which does not apply)*

(date authority for guardianship would have expired, apart from any extension under section 21, or date on which it will expire)

(b) was/is* subject to guardianship for a period ending on

and

(date)

(c) returned to that place on

In my opinion

(a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act

AND

(b) it is necessary

*(*delete (i) or (ii) unless both apply)*

(i) in the interests of the welfare of the patient
(ii) for the protection of other persons

that the patient should remain under guardianship under the Act.

My reasons for this opinion are:

(your reasons should cover both (a) and (b) above. As part of them describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient cannot appropriately be cared for without powers of guardianship.)

*(*delete the phrase which does not apply)*

The authority for the guardianship of the patient is/is not* due to expire within a period of two months beginning with the date on which this report is to be furnished.

Complete the following only if the authority for guardianship is due to expire within that period of two months.

*(*delete the phrase which does not apply)*

This report shall/shall not* have effect as a report duly furnished under section 20(6) for the renewal of the authority for the guardianship of the patient.

(delete whichever does not apply)

Signed:

Responsible Clinican/Nominated Medical Attendant

Name:

Date:

PART 2

(To be completed on behalf of the responsible local social services authority)

This report was received by me on behalf of the local social services authority

on

Signed:

on behalf of the local social services authority

Name: