Form CP 3

Regulation 17

Mental Health Act 1983 section 20A - report extending the community treatment period

PART 1

(To be completed by the Responsible Clinician)

To the managers of

(name and address of the responsible hospital)

(full name and address)

I am

the responsible clinician for

(full name and address of patient)

The patient is currently subject to a community treatment order made on

(date)

(date)

I examined the patient on

Please turn over

Form CP 3 (Cont'd)

In my opinion:

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
that the patient should receive such treatment

(delete any phrase which is not applicable)

(c) such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital

(e) taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient

My opinion is founded on the following grounds

(give grounds for opinion)

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if he or she were not detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Signed: …… the Responsible Clinician

Date: ……

PART 2

(To be completed by an approved mental health professional)

(full name and address)

I

am acting on behalf of

(name of local social services authority)

(delete as appropriate)

(name of LSSA that approved you, if different)

and am approved to act as an approved mental health professional for the purposes of the Act by that authority/

I agree that:

(i) the above patient meets the criteria for the extension of the community treatment period

AND

(ii) it is appropriate to extend the community treatment period.

Signed: …… an Approved Mental Health Professional

Date: ……

PART 3

(To be completed by the Responsible Clinician)

Before furnishing this report, I consulted

(full name and profession of the person consulted)

who has been professionally concerned with the patient's treatment.

I am furnishing this report by:

(delete the phrase which does not apply)

today consigning it to the hospital managers' internal mail system

sending or delivering it without using the hospital managers' internal mail system

Signed: …… the Responsible Clinician

Date: ……

PART 4

(To be completed on behalf of the hospital managers of the responsible hospital)

This report was

furnished to the hospital managers through their internal mail system

(date)

received by me on behalf of the hospital managers on

Signed: …… on behalf of the hospital managers

Name: ……

Date: ……

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