Yukon
Health and Social Services
Capability and Consent Board

Form 4
MENTAL HEALTH ACT
Sections 5 and 10

RECOMMENDATION FOR INVOLUNTARY PSYCHIATRIC ASSESSMENT (PHYSICIAN)

I N S T R U C T I O N S

This form must be completed by the physician following examination of the patient to assess his/her mental condition.

If recommending an assessment, copies of this form must be provided to the:

- ☐ Chief Executive Officer, Whitehorse General Hospital;
- ☐ patient;
- ☐ nearest relative, proxy or guardian if available; and
- ☐ Capability and Consent Board (fax 867-633-6954)

If patient is released, a copy of this form must be provided to the:

- ☐ Capability and Consent Board (fax 867-633-6954)

If travel is required, an Application for Medical Travel must accompany this form to Whitehorse General Hospital.

IN THE MATTER OF the *Mental Health Act*

AND IN THE MATTER OF _____**,** hereinafter called the patient.
Name of person

I, _____, a medical practitioner licensed to practise in the Yukon Territory, personally examined the patient, whose usual place of residence is _____, on _____
Date (day/month/year)

at _____ in _____, Yukon.
Time (a.m./p.m.)

1. Pursuant to sections 5 and 10 of the *Mental Health Act,* I undertook careful inquiry into the facts necessary to form a belief about the presence, nature and degree of severity of mental disorder at the time of assessment. The results of assessment are as follows:

Describe affective, cognitive and behavioural presentation of the patient upon interview/examination such as attitude, general appearance, motor behaviour, speech, emotional state, thought processes, thought content, perceptions, intellectual functioning, insight, judgment and diagnosis:

_____

_____

_____

_____

_____

_____

_____

☐ Check here if appending a copy of your admitting history as evidence for your opinions; the original is to be filed on the patient's medical record.

2. When information based on prior knowledge is used to form your opinion, complete this section.

_____
Describe your prior knowledge

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. When information not observed directly by you is used to form your opinion, complete this section.

The following behaviour of the patient was observed by others and communicated to me.

a) Source of information _____
Name the source and describe relationship to the patient

b) Direct observations were made by _____
Give name and describe relationship to the patient

c) Approximate date and time of observations _____

d) Brief description of observations _____
Describe affective, cognitive and/or behavioural observations

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Select A or B or C

☐ **A** It is my opinion that at this time the patient is not suffering from a mental disorder and should be released.

OR ☐ **B** It is my opinion that at this time the patient is suffering from a mental disorder and, further, it is my opinion that the patient is **not** likely to cause bodily harm to himself or herself or any other person as a result of the mental disorder **nor** is the patient likely to suffer impending serious physical impairment as a result of the mental disorder and should be released.

OR ☐ **C** It is my opinion the patient is suffering from a mental disorder. Further, I believe on reasonable grounds that the person, as a result of a mental disorder is:

☐ threatening or attempting to cause bodily harm to himself or herself or has recently done so **AND** is likely to cause bodily harm to himself or herself, on the grounds that:

Provide evidence in support of your opinion

_____

_____

_____

OR ☐ behaving violently towards another person or has recently done so **AND** is likely to cause bodily harm to another person, on the grounds that:

Provide evidence in support of your opinion

_____

_____

_____

OR ☐ causing another person to fear bodily harm or has recently done so **AND** is likely to cause bodily harm to another person, on the grounds that:

Provide evidence in support of your opinion

_____

_____

_____

OR ☐ showing or has recently shown a lack of ability to care for himself or herself **AND** is likely to suffer impending serious physical impairment, on the grounds that:

Provide evidence in support of your opinion

_____

_____

_____

AND Based on the information recorded on this form, I recommend that the patient be involuntarily psychiatrically assessed in _____
Name of designated facility

DATED at _____,

this _____ day of _____ (month), _____ (year).

_____
SIGNATURE OF PHYSICIAN

_____
PRINTED NAME OF PHYSICIAN

_____
SIGNATURE OF WITNESS