KARNATAKA CHAPTER

Mental Health Care Act 2017

Comprehensive Compilation of Essential Forms and Applications

Compiled by

Forensic Psychiatry Unit
Department of Psychiatry
NIMHANS Bengaluru

&

Mental Health Review Board: Bengaluru- Mysuru Division

An initiative of

INDIAN PSYCHIATRIC SOCIETY KARNATAKA CHAPTER

In association with

INDIAN PSYCHIATRIC SOCIETY SOUTH ZONAL BRANCH

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Dear Members,

The IPS Karnataka Chapter and IPS South Zonal Branch are pleased to announce the completion of a comprehensive compilation of essential forms and applications mandated under the Mental Healthcare Act 2017. This initiative is designed to streamline compliance processes and provide easy access to all necessary documentation for effective implementation of the ActÊs provisions.

We extend our sincere gratitude to the Forensic Psychiatry Unit, Department of Psychiatry, NIMHANS, and the Mental Health Review Board (Bengaluru-Mysore Division), Karnataka, for their invaluable support and expertise in this effort. Their commitment has been instrumental in creating a resource that will benefit practitioners across the country, ensuring uniformity in compliance and supporting high standards in mental healthcare.

We urge all members to align their practices with the Mental Healthcare Act 2017, which sets forth a comprehensive framework to uphold the rights and dignity of persons with mental illness. These compiled forms and applications are vital tools for maintaining ethical standards and accountability in mental health services. We encourage you to utilize this resource to strengthen rights-based care and ensure adherence to legal standards in your practice. If you have any doubts please do contact an advocate for a legal opinion.

Warm regards,

Dr Somashekhar Bijjal
President
IPS Karnataka Chapter

Dr Abhay Matkar
President
IPS South Zonal Branch

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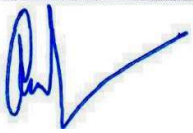
PART 1

Capacity Assessment Guidance Document

As per Section 81 of

Mental Healthcare Act, 2017



An Expert Committee to prepare a guidance document on Capacity Document

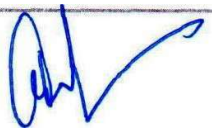
As per Section 81 (1) of the Mental Healthcare Act, 2017, the Chairman, Central Mental Health Authority appointed an Expert Committee to prepare a guidance document for medical practitioners and mental health professionals, containing procedures for assessing, when necessary or the capacity of persons to make mental health care or treatment decisions. Following Central Authority members were appointed for drafting the guidance document

Dr. B.N. Gangadhar, Chairman of this committee
Dr. Nimesh Desai
Dr. Rajesh Sagar
Dr. Prashant Mishra
Dr. Gorav Gupta
Ms. Rajeshwari lyer
Mr. Akileshwar Sahay

Mr. D.R. Sachadeva (invited)

The committee acknowledges the contribution of the following professionals in the development of the Capacity Assessment Guidance Document

Dr. Jagadisha Thirthahalli, Professor of Psychiatry, NIMHANS, Bangalore
Dr. Suresh Bada Math, Professor of Psychiatry, NIMHANS, Bangalore
Dr. Nitin Gupta, Professor of Psychiatry, GMCH, Chandigarh
Dr. Naveen C Kumar, Additional Professor of Psychiatry, NIMHANS, Bangalore

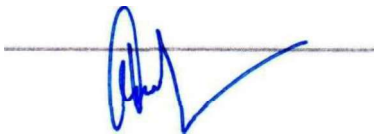


Capacity Assessment as per Mental Healthcare Act, 2017

Overview

Capacity is the ability to make a particular decision, having understood the information relating to the decision at hand and appreciating the consequence of making or not making that decision. Capacity is not static, but dynamic in nature. People may have a condition or illness that affects their ability to make decisions. A lack of capacity may be temporary such as that caused by some illnesses or the influence of drugs or alcohol or mood / affective state. A person's capacity may vary over time depending on the condition or illness that the person experiences.

A person is presumed to have the capacity to make a decision unless there are good reasons to doubt this presumption. In general, capacity is assessed with respect to a specific decision at a specific time. A person is entitled in law to make unwise or imprudent decisions, provided they have the capacity to make the decision. Supported decision-making involves doing everything possible to maximise the opportunity for a person to make a decision for themselves. As per the MHA, 2017All persons with mental illness shall have capacity to make mental healthcare or treatment decisions but may require varying levels of support from their nominated representative to make decisions. A person's capacity should be assessed in relation to a particular task or decision. Capacity cannot generally be inferred fromone task or decision to another. The person's lack of capacity may be temporary, or fluctuating. If possible, an assessment of capacity should be done when the person's condition has improved. For example, if the person has a delirium, it is better to wait until this has resolved. In such patients with Delirium, Severe Manic Excitement, Stupor, Alcohol and other substance use intoxication, Capacity Assessment may not be feasible, and they can be deemed to have "Obvious" lack of capacity and may be recorded as such. Finally, the capacity assessment is based on combination of relevant history, symptoms, behavior observation, mental status examination and diagnosis. It is a clinical judgement of a clinician.



Guidance document is drafted as per the Section 81 of the MHA, 2017

81. *(1)* The Central Authority shall appoint an Expert Committee to prepare a guidance document for medical practitioners and mental health professionals, containing procedures for assessing, the capacity of persons to make mental health care or treatment decisions.

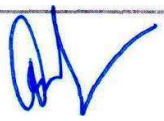
(2) Every medical practitioner and mental health professional shall, while assessing capacity of a person to make mental healthcare or treatment decisions, comply with the guidance document referred to in sub-section *(1)* and follow the procedure specified therein.

This guidance document is only a guidance document and does not replace the legal advice. This document is not a structured or checklist instrument and only a guidance document with provision for semi-structured assessment and documenting the capacity assessment findings. The final decision of capacity is based on holistic assessment of behavioral observation, clinical findings, mental status examination, diagnosis and capacity assessment as per the guidance document. Further it is the prerogative and the duty of the Mental Health Professional/Clinician to record the clinical findings in details and/or elaboration of the same.

Mental Healthcare **Act, 2017 articulates following regarding** the Capacity to make mental healthcare and treatment decisions.

4. *(1)* Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment if such person has ability to —

(a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance;

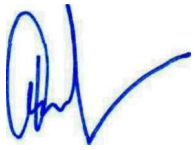


(b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance;

(c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means.

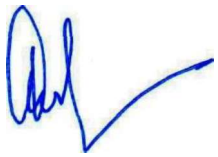
(2) The information referred to in sub-section *(1)* shall be given to a person using simple language, which such person understands or in sign language or visual aids or any other means to enable him to understand the information.

(3) Where a person makes a decision regarding his mental healthcare or treatment which is perceived by others as inappropriate or wrong, that by itself, shall not mean that the person does not have the capacity to make mental healthcare or treatment decision, so long as the person has the capacity to make mental healthcare or treatment decision under sub-section *(1).*



Assessment of capacity to make mental healthcare and treatment decisions is to be carried out on any person (above 18 years of age) during the following situations: -

a) The registration of Advance directives as per Section 11(2)d
b) Before invoking the Advance directive as per Section 5(3)
c) Independent admission as per Section 86(2)c
d) Supported Admission as per Section 89(1)c
e) Every week, when admitted under section 89(8)
f) Supported Admission as per Section 90(12)
g) Every fortnightly, when admitted under Section 90(13)
h) Before giving any information under Section 22 of the person to the Nominated representative (information will be given to NR only if the PMI do not have capacity)
i) For treatment related decisions (other than admission) as per Section 4



Capacity Assessment for Treatment decisions including Admission

Name of the patient.....

Age..... Sex.....

Patient ID No.....

Date of Assessment.....time.....

Place of Assessment .....

Purpose of this Assessment: Admission *I* Treatment / AD / Any Other

(If admitted under Section 102/103 of MHA, 2017 the rest of the assessment canhappen in the ward)

Advance Directive .....(Present/Absent)

Nominated Representative: Name:.....
ID:.....

Diagnosis (provisional).....

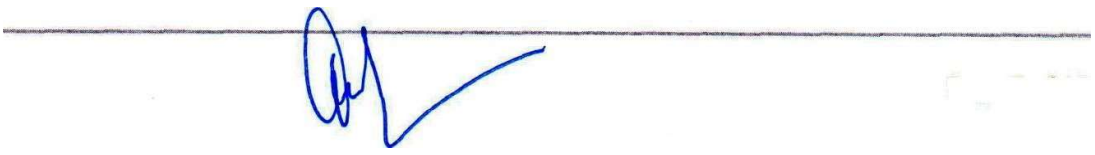
Note: Provide explanation for each question

Obvious lack of capacity:

Is he/she in a condition, that that one cannot have any kind of meaningful conversation with him/her (such as being violent, excited, catatonic, stuporous, delirious, under alcohol or substance intoxication/severe withdrawal, or any other (explain below))

(Yes / No)

If yes, then go to 4. If no, then go to 1.



1. Understanding the information that is relevant to take a decision on the treatment or admission or personal assistance (Understands the nature and consequences of the decision; possible options explained)
    a. Is the individual oriented to time, place and person? (Yes / No / Cannot assess)

    Explanation:

    b. Has he/she been provided relevant information about mental healthcare and treatment pertaining to the illness in question? (Yes / No)

    If no, provide explanation:

    c. Is he/she able to follow simple commands like (i) show your tongue (ii) close your eyes (Yes / No / Cannot assess)?

    Explanation:

    d. Does he/she acknowledge that he has a mental illness? (Yes / No / Cannot assess)

    Explanation:

2. Appreciating reasonably foreseeable consequence of a decision or lackof decision on the treatment or admission or personal assistance.

   a. Does the individual agree to receive treatment suggested by the treating team? (Yes / No / Cannot assess)

   Explanation:

If yes, go to 2b. If no, go to 2c. *If cannot assess, go to 3*

   b. Does he/she explain why he/she has agreed to receive treatment? (Yes / No / Cannot assess)

   Explanation:

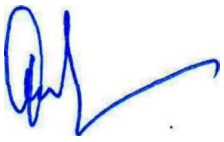
   c. Does he/she explain why he/she does not agree to receive treatment? (Yes / No / Cannot assess)

   Explanation:

3. **Communicating the decision under sub-clause (1) by** means of speech, **expression, gesture or** any **other** means **(Specify).**

   a. Is the individual able to communicate his/her decision by means of speech, writing, expression, gesture or any other means? (Yes / No /Cannot assess)

   Explanation:



4. Based on the examination and relevant history, behavioral observation, clinical findings and mental status examination findings noted in the medical records, I believe that Mr. / Ms. .....(Strike off the choice that is not applicable)

a. Has capacity for treatment decisions including admission
b. Needs 100% support from his/her nominated representative in making treatment decisions including admission

Signature of the Psychiatrist/Mental health professional/
Medical Practitioner ....

Name of the Psychiatrist/Mental health professional/
Medical Practitioner ....

5. Fill the following if the choice is 4.a.:

I, Mr. / Ms....., agree *to make decisions in respect of my mental healthcare and treatment.*

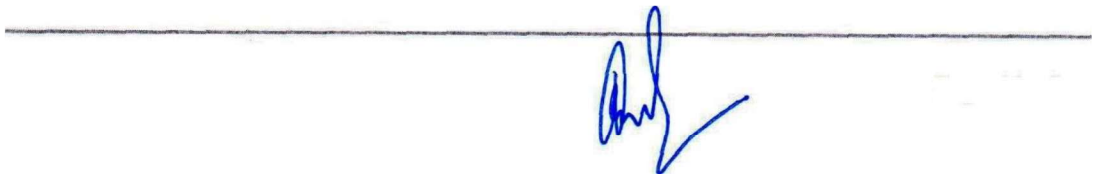
Signature of the assessed person (if it is 4.a). *Name of the assessed person:*

6. Fill the following if the choice is 4.b.:

I, Mr. / Ms....., *the nominated representative of Mr. /Ms. .....agree to make* dec/sions *with respect of his/her treatment.*

Signature of the Nominated Representative (if it is 4.b).....

Name of the Nominated Representative:.....



Capacity Assessment for Treatment decisions including Admission

Name: **Age/Sex:** **P.No.:** **Date/Time:**
Place of assessment: **Advance Directive:** Present/Absent

Purpose of this assessment: Admission/Treatment/Advance Directive/Any Other

(For admission under section 102/103 of MHCA 2017, rest of the assessment can happen in the ward)
Nominated Representative: Name: ID:

Diagnosis (provisional):

Note: Provide explanation for each question

Obvious lack of capacity	Is he/she in a condition, that that one cannot have any kind of meaningful conversation with him/her (such as being violent, excited, catatonic, stuporous, delirious, under alcohol or substance intoxication/severe withdrawal, or any other (explain below)) .....? (Yes/No) If yes, then go to 4. If no, then go to 1.

1. Understanding the information that is relevant to take a decision on the treatment or admission or personal assistance (Understands the nature and consequences of the decision; possible options explained)			
A. Is the individual oriented to time, placeand person? (Yes/No/Cannot assess) Explanation:	**B**. Has he/she been provided relevant information about mental healthcare and treatment pertaining to the illness in question? (Yes/No) If no, provide explanation:	**C.** Is he/she able to follow simple commands like (i) show your tongue (ii) close your eyes? (Yes/No/Cannot assess)? Explanation:	**D.** Does he/she acknowledge that he has amental illness? (Yes/No/Cannot assess) Explanation:

2. Appreciating reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance.

A. Does the individual agree to receive treatment suggested by the treating team? (Yes/No/Cannot assess) Explanation: If yes, go to 2b. If no, go to 2c. If cannot assess, go to 3	**B.** Does he/she explain why he/shehas agreed to receive treatment? (Yes/No/Cannot assess) Explanation:	**C.** Does he/she explain why he/she does not agree to receive treatment? (Yes/No/Cannot assess) Explanation:

3. Communicating the decision as per question (1) by means of speech, expression, gesture or any other means(Specify).

A. Is the individual able to communicate his/her decision by means of speech, writing, expression, gesture or any othermeans? (Yes/No/Cannot assess)
Explanation:

4. Based on the examination and relevant history, behavioral observation, clinical findings and mental status examination findings noted in the medical records,

I believe that Mr./Ms. ……(Strike off the choice that is not applicable)

a. Has capacity for treatment decisions including admission
b. Needs 100% support from his/her nominated representative in making treatment decisions including admission

Name and Signature of the Psychiatrist/Mental health professional/ Medical Practitioner

5. Fill the following if the choice is 4.a.:
I, Mr./Ms. …… , agree to make decisions in respect of my mental healthcare and treatment.

Name and Signature of the Patient
Date……

6. Fill the following if the choice is 4.b.:
I, Mr./Ms. ...., the nominated representative of Mr./Ms. .....
agree to make decisions with respect of his/her treatment.

Name and Signature of the Nominated Representative
Date……..

ADDITIONAL REFERENCES FOR CAPACITY ASSESSMENT

PART 2

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE-29

(Institute of National Importance)

Form – C

Request for independent admission at NIMHANS, Bangalore-560029

(MHCA 2017 Sec 86 & Rule 8)

To, Date:

The Psychiatrist,

Unit -…… Department of Psychiatry,

NIMHANS, Bangalore

Sir/Madam,

I, Mr./Mrs./Ms. _____Hospital No. _____ age ____ son/daughter of _____, residing at _____have mental illness with following symptoms since _____

1. _____
2. _____
3. _____

The following papers related to my illness as available with me are enclosed:

1. _____
2. _____
3. _____

I wish to be admitted in your establishment for treatment and request you to please admit me as an independent patient.

Mr./Mrs/Ms _____, who is my _____ (specify relationship) will be staying with me during my admission period to help in the treatment process. A self-attested copy of my identity Proof is enclosed.

Address……

……

…… ..Mobile no……

Alternative Mobile/Land Line no …… ..

Email……

Signature ……..

Name ……

Date & Time ……

List of enclosures:

……

……

……

……

……

……

N.B:- Please strike off those which are not required

Form – E

Request for Admissions with High Support Needs at NIMHANS, Bangalore-560029

(MHCA 2017 Sec 89 and Rule 8)

To, Date:
The Psychiatrist,
Unit ..... Department of Psychiatry,
NIMHANS, Bangalore

Sir/Madam,

I, Mr. / Mrs./Ms. ....., residing at .....

Nominated representative of Mr./Mrs/Ms..... Hospital No.....

aged..... son/daughter of .....request for his/her admission in your establishment for treatment of mental illness.

Mr./Mrs./Ms. ..... has / not written Advance Directive.

Mr./Mrs/Ms .....has been having the following symptoms since _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

The following papers regarding my appointment as nominated representative and information related to treatment of his/her mental illness are enclosed:

1. Advance Directive
2. _____
3. _____
4. _____
5. _____
6. _____

A self-attested copy of my identity Proof is also enclosed.

Kindly admit him/her in your mental health establishment as patient with high support needs.

Address.....
.....
..... .Mobile no.....
Alternative Mobile/Land Line no .....
Email:.....

Signature .....
Name .....
Date & Time .....

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE-29

(Institute of National Importance)

Form – F

Request for Continuous Admissions with High Support Needs at NIMHANS, Bangalore-560029

(MHCA 2017 Sec 90 and Rule 8)

To, Date:

The Psychiatrist,

Unit ……..…. Department of Psychiatry,

NIMHANS, Bangalore

Sir/Madam,

I, Mr. / Mrs./Ms. ……., residing at ……

Nominated representative of Mr./Mrs/Ms…… Hospital No…….

aged……. son/daughter of ……, who is/was an inpatient in your establishment under supported admission category, request for his/her continued admission beyond thirty days/readmission within seven days of discharge for the reasons stated below.

1……..
2……..
3……..
4……..
5……..

Kindly continue his/her admission /readmit him/her in your mental health establishment as patient with high support needs beyond thirty days.

Mr./Mrs./Ms. …….. has/ not written Advance Directive.

A self-attested copy of my photo identity Proof is enclosed.

Address…… …..
…… ……
……Mobile no……..
Alternative Mobile/Land Line no …… ...
Email:…… .

Signature ……..
Name ……
Date & Time ……

List of enclosures:

1) Copy of the self-attested photo ID proof
2) Copy of the Advanced Directives
3) ……
4) ……
5) ……
6) ……
7) ……

Form - G

REQUEST FOR DISCHARGE BY INDEPENDENT PATIENT
[MHCA 2017 Sec 88 and rule 8]

To,
The Psychiatrist,
Unit …… Department of Psychiatry,
NIMHANS, Bangalore

Date:

Sir/Madam,

Subject: - Request for discharge.

I, Mr. /Mrs. …… Hospital No……
residing at ……aged…… son/daughter of……, was admitted in your mental health establishment as an Independent admission patient on …… I now feel better and wish to be discharged. If any other reason/s for discharge, please mention below

1 ……
2 ……
3 ……

Kindly arrange to discharge me immediately.

Address……
……
…… ..Mobile no……
Alternative Mobile/Land Line no …… ……
Email:……

Signature ……
Name ……
Date & Time ……

N.B.:- Please strike off those which are not required

Form - D

REQUEST FOR ADMISSION OF A MINOR
(u/s 87 of MHCA, 2017 and Mental Healthcare rules, 2018)

To,
The Medical Officer in-charge
_____
_____

Sir/Madam,

I, Mr. /Mrs._____residing at _____, who is the nominated representative (being legal guardian) of Master/Miss_____, request you to admit Master/Miss_____ aged_____son/daughter of_____, for treatment of mental illness:

He/she is having the following symptoms since ____

1. _____
2. _____
3. _____

The following papers related to my being the nominated representative and his/her illness are enclosed:

1. _____
2. _____
3. _____
4. _____

Kindly admit him/her in your establishment as minor

patient.Address:

Mobile:
E-mail: Signature of applicant
Date: Name of applicant

N.B.:- Please strike off those which are not required.

Form – H

(Adapted from The Mental Healthcare (Rights of persons with mental illness) rules, 2018)

REQUEST FOR DISCHARGE OF A MINOR BY ITS NOMINATED REPRESENTATIVE

To,
The Medical Officer in-charge
_____
_____

Sir/Madam,

Subject: - Request for discharge.

I am the nominated representative of Mr. /Ms._____residing at _____aged_____son/daughter of _____who was admitted in your mental health establishment as a minor patient on_____. Mr./Ms._____now feel better and wish to be discharged. Kindly arrange to discharge him/her immediately.

Address
Date
Mobile
Email

Signature of the applicant

Name of the applicant

N.B.:- Please strike off those which are not required.

Application for NR for minors

(Application **u/s** 1**5 (2)** of Mental Health Care Act of 2017)

I.	**Particulars of the mental health establishment:**	
	a) Name:	
	b) E-mail Id.	
	c) Contact number:	
	d) Date of registration	
	e) Registered number:	
II.	**Particulars of minor with mental illness:**	
	a) Name:	
	b) Age/ Date of Birth:	
	c) Name of the father:	
	d) Name of the mother:	
	e) Date of admission:	
	f) Place of residence:	
	h) Hospital id:	
	i) Aadhaar card number: (**NOTE:** Aadhaar card Copy for identification **must be attached**)	
III.	**Particulars of the person who admitted the minor:**	
	a) Name:	
	b) Male/ female	
	c) Age/ Date of Birth:	
	d) Name of the father:	
	e) Place of residence:	
	f) Contact mobile number	
	g) Relation with the minor	
	h) Aadhaar card number: (**NOTE:** Aadhaar card Copy for identification **must be attached**)	
IV.	**Particulars of the Mental Health Professional who submitted application to the Board for appointment of Nominated Representative for minor:**	
	a) Name:	
	b) Designation	
	c) Registration number	
	d) Mobile contact number:	
	e) E-mail Id	
V.	**Particulars of person acting in the best interest of minor & wants to be NR**	
	a) Name:	
	b) Male/Female:	
	c) Father's Name:	
	d) Place of residence:	
	e) Mobile contact number:	
	f) E-Mail Id:	
	g) Aadhaar card number: (**NOTE:** Aadhaar card Copy for identification **must be attached**)	

	Particulars of suitable individual person who is willing to act as nominated representative:

	(If available, the name may be suggested by the applicant)	
	a) Name:	
	b) Male/ Female:	
	c) Father's Name:	
	d) Place of residence:	
	e) Mobile contact number:	
	f) E-mail Id	
	g) Aadhaar card number: (**NOTE:** Aadhaar card Copy for identification **must be attached**)	
VI.	Evidence presented before the Board by the applicant to show that, legal guardian is not acting in the best interest of the minor **to be attached.**	
VII	Documentary evidence presented before the board by the applicant to show that, the legal guardian is otherwise not fit to act as the nominated representative of the minor **to be attached.**	
VIII.	Whether individual is available for appointment as nominated representative for the minor?	

Therefore, for the above reasons the applicant requests for appointment of nominated representative for minor person with mental illness…….. patient number ..... as early as possible.

-: Certificate: -

I, hereby certify that the information furnished above are true and correct to the best of personal knowledge.

Place: Signature of the applicant
Date: Name of the applicant

Permission for ECT for Minors

Application **u/s 95 (2)** of the Mental Healthcare Act of 2017)

I.	**Particulars of the mental health establishment**	
	a) Name:	
	b) E-mail Id.	
	c) Contact number:	
	d) Date of registration	
	e) Registered number:	
II.	**Particulars of the mental health professional who is treating the minor with mental illness**	
	a) Name:	
	b) Designation	
	c) Qualification	
	d) Registration number	
	e) Mobile contact Number	
	f) E-mail id	
III.	**Particulars of minor who needs ECT:**	
	a) Name:	
	b) Age/ Date of Birth:	
	c) Name of the father:	
	d) Name of the mother:	
	e) Date of admission:	
	f) Place of residence:	
	g) Name of the Department:	
	h) Hospital id:	
	i) Aadhaar card number: **NOTE:** Aadhaar card Copy for identification must be **attached**)	
IV.	**Particulars of the natural/legal guardian (Mother or Father) who has given consent to perform ECT.**	
	a) Name:	
	b) Father's name:	
	c) Mother's name:	
	d) Age:	
	e) **Relationship with minor**:	
	f) Male/Female:	
	g) Contact number:	
	h) E-mail id:	
	i) Postal address: **NOTE:** Aadhaar card Copy for identification must be **attached.**	
V.	**Particulars of the Nominated Representative for minor appointed by the Review Board who has given consent to perform ECT.**	
	a) Name:	
	b) Father's name:	
	c) Mother's name:	
	d) **Relationship with minor**:	
	e) Male/Female:	
	f) Contact number:	
	g) E-mail id:	

	h) Postal address: **NOTE:** Aadhaar card Copy for identification must be **attached.**	
VI.	Whether giving ECT treatment for the minor is very much necessary and is un-avoidable**?** **If yes, the report with reasons must be attached.**	
VII.	Whether a copy of the **written informed consent** for ECT duly signed by the natural/legal guardian/nominated representative and the same is certified by the psychiatrist treating the minor **is attached**?	

Therefore, for the above reasons the applicant requests for prior permission for Electro-Convulsive Therapy treatment for minor…….
patient number.....as early as possible.

-: Certificate: -

I, hereby certify that the information furnished above are true and correct to the best of our personal knowledge.

Place
Date

Signature of the applicant
Name of the applicant

Form - I

REQUEST FOR LEAVE OF ABSENCE
(By Nominated Representative)
[MHCA 2017 Sec 91 and rule 9]

To, Date:
The Psychiatrist,
Unit ..... Department of Psychiatry,
NIMHANS, Bangalore

Sir/Madam,

Subject: - Request for leave of absence

Mr. / Mrs /Ms ..... Hospital No.....
residing at ..... aged ..... years was admitted on .....to your mental health establishment.

I, as nominated representative Mr. /Mrs/Ms .....request that he/she be granted leave of absence from (date & time)..... to..... ..... for the reason stated below:

1 .....
2 .....
3 .....

The proof of my appointment as nominated representative is enclosed.

I will be responsible for care and treatment of Mr./Mrs/Ms.....
while he/she is on leave of absence from the mental health establishment.

Address.....
.....
....Mobile no.....
Alternative Mobile/Land Line no ....
Email:.....

Signature .....
Name .....
Date & Time
.....

N.B.:- Please strike off those which are not required.

APPLICATION FOR PSYCHOSURGERY

(Application u/s 96 of the Mental Healthcare Act of 2017 and under Regulation 17 of Mental Healthcare (Central mental HealthAuthority) Regulations, 2020)

1.	Name of the mental health establishment.	
2.	Date of registration and registered number of mental health establishment.	
3.	Name of the medical officer who is treating the person with mental illness and his/her contact number and e-mail id.	
4.	Name of the mental health professional in charge of a mental health establishment and his/her contact number and e-mail id.	
5.	Name of the head of the department of psychiatry and his/her e-mail id and contact number:	
6.	Name of the medical superintendent and his/her e-mail id and contact number:	
7.	Name of the qualified neurosurgeon who is performing psychosurgery.	
8.	Particulars of person who is undergoing psychosurgery:	
	a) Name:	
	b) Age:	
	c) Date of admission:	
	d) Department Name:	
	e) Patient No:	
	g) Aadhaar card for identification:	
9.	Name of the medical officer or mental health professional (qualified psychiatrist and neurosurgeons) who opined about the necessity of performing the psychosurgery.	
10.	Consent of the patient to undergo psychosurgery taken or not	
11.	Whether a certified copy of the written informed consent for psychosurgery duly signed by the person on whom it is proposedto be performed is enclosed along with the application?	
12.	Whether a detailed submission by the attending psychiatrist with clinical summaryof the case, explaining and justifying the need, suitability and safety of the proposed psychosurgery is enclosed along with the application?	

13.	Whether certified copies of such person's medical records are enclosed along with the application?	
14.	Whether the mental health establishment is equipped with medical facilities and qualified neurosurgeons for undertaking the psychosurgery?	

Therefore, for the above reasons, approval to perform psychosurgery procedure as a treatment for mental illness may kindly be granted.

-: Certificate: -

I, hereby certify that the information furnished in the above proforma are true and correct to the best of my personal knowledge.

Place
Date

Signature of the applicant
Name of the applicant

FORM – A

(Central Mental Health Authority
regulations, 2020)

FORM FOR MAKING, AMENDING/ REVOKING AND CANCELLING ADVANCE DIRECTIVE

1. Name (Attach copy of photo identity document proof): _____
2. Age (Attach copy of age proof for being above 18 years of age):_____
3. Father's/ Mother's Name:_____
4. Address (Attach copy of proof):_____

   Note.- Any valid identity proof like Birth Certificate, Driving License, Voter's Card, Passport, Aadhaar card, etc. shall be admissible as address proof and age proof.

5. Contact number(s):_____
6. Registration no. of previous advance directive (to be filled in case of amendment/ revocation/ cancellation of advance directive):_____
7. I wish to be cared for and treated as under (not to be filled in case of revocation/ cancellation of advance directive):
   _____
   _____
8. I wish not be cared for and treated as under (not to be filled in case of revocation/ cancellation of advance directive):
   _____
   _____
9. Any history of allergies, known side effects, or other medical problems
   _____
   _____
10. I have appointed the following persons in order of precedence(Enclosed photo ID and age proof), who are above 18 years of age to act as my nominated representatives to make decisions about my mental illness treatment, when I am incapable to do so (not to be filled in case of revocation/ cancellation of advance directive):

(a) Name: _____Age_____

Father's/Mother's name: _____

Address: _____

Contact number(s): _____

Signature: ..... Date_____

(b) Name: _____Age_____

Father's/Mother's name: _____

Address: _____

Contact number(s): _____

Signature: ..... Date_____

[Any number of nominated representatives can be added]

11. Signature of applicant ..... Date_____
12. Signature of witnesses:
13. Mr./ Ms. _____has the mental capacity to make/ amend/ revoke/ cancel an advance directive at the time of signing this form and has signed it in our presence of his/ her own free will.
    - Witness 1: (Name)…….(Signature)…….Date……...
    - Witness 2: (Name)…….(Signature)…….Date……..

Enclosure(s):

Note.- Please strike off those which are not required.

PART 3

Form-B

APPLICATION FOR GRANT OF PROVISIONAL REGISTRATION/ RENEWAL OF PROVISIONAL REGISTRATION OF A MENTAL HEALTH ESTABLISHMENT

(SMHA Rules, 2018)

To

The.....

Department of ……..

State Government of .....

.....

Dear Sir/ Madam,

I/we intend to apply for grant of provisional registration/ permanent registration/ renewal of provisional registration for the Mental Health Establishment namely ..... of which I am/we
are holding a valid licence/registration for the establishment/ maintenance of such hospital/nursing home. Details of the hospital/nursing home are given below:

1. Name of applicant .....
2. Details of licence with reference to the name of the authority issuing the licence and date.....
3. Age .....
4. Professional experience in Psychiatry .....
5. Permanent address of the applicant .....
6. Location of the proposed hospital /nursing home .....
   .....
7. Address of the proposed nursing home/hospital .....
8. Proposed accommodations: .....

   (a)Number of rooms .....

   (b) Number of beds .....

   (c)Facilities provided: .....

   (d) Out-patient .....

   (e)Emergency services .....

   (f) In-patient facilities .....

   (g) Occupational and recreational facilities .....

   (h) ECT facilities (n X-Ray facilities .....

   (i) Psychological testing facilities .....

   (j) Investigation and laboratory facilities .....

   (k) Treatment facilities .....

Staff pattern:

(a) Number of doctors .....

(b) Number of nurses .....

(c) Number of attendees .....

(d) Others .....

I am herewith sending a bank draft for Rs..... drawn in favour of as application fee.

I hereby undertake to abide by the rules and regulation of the Mental Health Authority.

I request you to consider my application and grant the licence for establishment/ maintenance of psychiatrichospital/nursing home.

Yours faithfully
Name
Signature

Date

Form-C

CERTIFICATE OF PROVISIONAL REGISTRATION/ RENEWAL OF PROVISONAL REGISTRATION
(SMHA Rules, 2018)

The State Authority, after considering the application dated……..submitted by under section 65 (2)
or section 66 (3) or section 66(10) of the Mental Healthcare Act, 2017, hereby accords provisional registration/renewal of provisional registration to the applicant mental health establishment in terms of section 66 (4) or section 66 (11), as per the details given hereunder:

Name:_____ Address_____

No of beds_____

The provisional registration certificate issued, is subject to the conditions laid down in the Mental Healthcare Act,2017 and the rules and regulations made there under and shall be valid for a period of twelve months from the date of its issue and can be renewed.

Place

Date

Registration authority Seal of the registration authority

Form-B

APPLICATION FOR GRANT OF PROVISIONAL REGISTRATION/ RENEWAL OF PROVISIONAL REGISTRATION OF A MENTAL HEALTH ESTABLISHMENT

(CMHA Rules, 2018)

To

The.....

Ministry/

Department

Government of

India

.....

Dear Sir/ Madam,

I/we intend to apply for grant of provisional registration/ permanent registration/ renewal of provisional registration for the Mental Health Establishment namely..... of which I am/we
are holding a valid licence/registration for the establishment/ maintenance of such hospital/nursing home. Details of the hospital/nursing home are given below:

1. Name of applicant .....
2. Details of licence with reference to the name of the authority issuing the licence and date.....
3. Age .....
4. Professional experience in Psychiatry .....
5. Permanent address of the applicant .....
6. Location of the proposed hospital /nursing home .....
   .....
7. Address of the proposed nursing home/hospital .....
8. Proposed accommodations: .....
   (a)Number of rooms .....
   (b) Number of beds .....
   (c)Facilities provided: .....
   (d) Out-patient .....
   (e)Emergency services .....
   (f) In-patient facilities .....
   (g) Occupational and recreational facilities .....
   (h) ECT facilities (n X-Ray facilities .....

Staff pattern:

(i) Psychological testing facilities .....

(j) Investigation and laboratory facilities .....

(k) Treatment facilities .....

(a) Number of doctors .....

(b) Number of nurses .....

(c) Number of attendees .....

(d) Others .....

I am herewith sending a bank draft for Rs..... drawn in favour of as application fee.

I hereby undertake to abide by the rules and regulation of the Mental Health Authority.

I request you to consider my application and grant the licence for establishment/ maintenance of psychiatric hospital/nursing home.

Yours Faithfully

Signature

Name

Date

Form-C

CERTIFICATE OF PROVISIONAL REGISTRATION/ RENEWAL OF PROVISIONAL REGISTRATION

(CMHA Rules, 2018)

The Central Authority/ State Authority, after considering the application dated ..... submitted by ..... under section 65 (2) or section 66 (3) or section 66(10) of the Mental Healthcare Act, 2017, hereby
accords provisional registration/renewal of provisional registration to the applicant mental health establishment in terms of section 66 (4) or section 66 (11), as per the details given hereunder:

Name:_____

Address_____

No of beds_____

The provisional registration certificate issued, is subject to the conditions laid down in the Mental Healthcare Act,2017 and the rules and regulations made there under and shall be valid for a period of twelve months from the date of its issue and can be renewed.

Place — Registration authority

Date — Seal of the registration authority

FORM – C

APPLICATION FOR PERMANENT REGISTRATION OF A CENTRAL MENTAL HEALTH ESTABLISHMENT
(CMHA Regulations, 2020)

1. Name of the establishment:
2. Postal address:
3. Category:
4. Name, qualifications and experience of the in charge of the establishment:
5. Number of beds:
6. Past/ Current Registration No… ..... (Attach a copy)

   (In case registration was under the Clinical Establishments (Registration and Regulation) Act, 2010 (23 of 2010) or any other law, such Registration No with a copy of Registration Certificate be enclosed with this application)

7. Services provided (tick what is provided)
   (a) Out-patient
   (b) In-patient
   (c) Emergency
   (d) Day Care
   (e) Electro convulsive therapy
   (f) Imaging
   (g) Psychological testing
   (h) Investigation and laboratory
   (i) Any other (Specify)
8. Staff (Numbers):
   (a) Medical officers and specialists
   (b) Para-medical/ para-clinical staff
   (c) Attenders
   (d) Health educators
   (e) Multi-purpose workers
   (f) Others (Specify)

Details of registration fee paid:

DECLARATION

We hereby undertake to abide fully by the provisions of the Mental Health Care Act, 2017 (10 of 2017) and rules and the regulations made thereunder.

CONFIRMATION

We confirm that our establishment complies with the minimum standards specified under the Central Mental Health Authority Regulations, 2020 under which we are seeking registration.

PRAYER

We request for registration of our mental health establishment with the Authority.

Date

Place

Signed by the authorized signatory
(Name and designation of the signatory
Stamp of the mental health establishment

Enclosure:

PART 4

Independent Opinion of a Psychiatrist/ Medical practitioner/ Medical Officer in charge for Admission

(Under Sec 89 or 90 of MHCA 2017)

This is to certify that I, Dr……
working as a ……under unit-……have sought information of the history of presenting illness, examined personally and independently Mr./Ms./Mrs……
Hospital No …… son/daughter/spouse/others of Mr/Ms/Mrs ……

Please tick the appropriate choice below and provide explanation:-

1. has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself or
2. has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
3. has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself

Explanation for the choice/s

In my opinion, Mr/Mrs…… Hospital No _____requires supported admission under Sec 89 or 90.

…… ……

Name & Signature of the Psychiatrist

Medical practitioner/

Medical Officer in charge

Date: ……..

N.B.:- Please strike off those which are not required.

INTIMATION OF ADMISSION OF PERSON WITH MENTAL ILLNESS TO THE MENTAL HEALTH REVIEW BOARD

(u/s 87, 89 of MHCA, 2017)

I) Particulars of the person with mental illness admitted in the Mental Health Establishment			
a)	Name	:	
b)	Father's Name	:	
c)	Age	:	
d)	Male/Female	:	
e)	Place of Residence	:	
f)	Mobile Contact No.	:	
g)	E-mail I.D (if any.	:	
h)	Aadhaar Card No.	:	
i)	Patient No.	:	
j)	Date of Admission	:	
II) Particulars of nominated representative			
a)	Name	:	
b)	Father's Name	:	
c)	Age	:	
d)	Male/Female	:	
e)	Place of Residence	:	
f)	Mobile Contact No	:	
g)	E-mail ID (if any)	:	
h)	Aadhaar Card No	:	
i)	Relationship with patient (Ref: Sec. 14 of MHC Act, 2017)	:	
III) Particulars of mental health establishment			
a)	Name	:	NIMHANS, Bengaluru
b)	E-mail ID	:	ms@nimhans.ac.in
c)	Contact No	:	080-26995201
d)	Registration no. of Establishment	:	CMHA/2024/0001
e)	Date of Registration	:	13/3/24
f)	Name of the Mental health professional in charge of the mental health establishment.	:	Medical Superintendent NIMHANS, Bengaluru

IV	**Admission of minor**	
	Whether admission is intimated to the Board within 72 hours as required u/s 87(9) of the Act?	
V	**Supported admission of Minor/Woman up to thirty days**	
	Whether admission of minor/women is reported to the Board within three days of admission as required u/s 89(9)(a) of the Act?	
VI	**Continuous admission of minor**	

	Whether continuous admission of minor for a period of thirty days is immediately informed to the Board as required u/s 87[11] of the Act?	
VII	**Supported admission up to thirty days of any person**	
	Whether "any person not being a woman or minor is reported to the Board within seven days of admission as required u/s 89(9)(b) of the Act?	

CERTIFICATE

I hereby certify that, the above information provided in the proforma are true and correct to the best of my personal knowledge and based on the clinical/medical records maintained in this mental health establishment.

Place: ***NIMHANS, Bengaluru***
Date:

Senior Resident

Mental health professional in charge of the mental health establishment

(With seal and Signature)

Application seeking **permission <u>for continuation of admission or readmission or discharge of person</u>** with mental illness with high supported needs beyond thirty days. (**u/s 90 (5)** of the Mental Healthcare Act of 2017 **seeking)**

I.	**Particulars of Mental Health Establishment:**	
a.	Name of the mental health establishment:	
b.	Date of Registration and registered number of mental health establishment:	
c.	Name of the medical officer who is treating the person with mental illness and his/her contact number and e-mail id:	
d.	Name of the mental health professional in charge of a mental health establishment and his/her contact number and e-mail id:	
II.	**Particulars of the person with mental illness:**	
a.	Name of the person with mental illness:	
b.	Date of birth of person with mental illness:	
c.	Male/Female:	
d.	Date of admission:	
e.	Department Name:	
f.	Patient No:	
g.	Address: (Aadhaar card has to be enclosed)	
h.	Contact no:	
III.	**Particulars of Nominated Representative:**	
a.	Name:	
b.	Age:	
c.	Male/Female:	
d.	Address: (Aadhaar card has to be enclosed)	
e.	Relationship with the person with mental health illness:	
f.	Contact no:	
IV	**Particulars of information furnished by the medical officer or mental health professional for seeking permission for continuation:**	
a.	Name of the medical officer or mental health professional who has assessed and evaluated and diagnosed the illness:	
b.	Date of admission and treatment with high supported needs up to thirty days:	
c.	Whether admission or readmission u/s 90 (3) is **reported** to the Review Board within seven days from the date of admission.	

d.	Date of application by the Nominated Representative u/s 90 (2) of the Act for seeking continuation beyond thirty days with high supported needs. (Copy of the application of NR must be enclosed)	
e.	Whether admitted person under section 89 of the Act requires continues high supported treatment beyond thirty days?	
f.	Whether two psychiatrists have independently examined the person with mental illness in the preceding seven days? (Copy of medical records must be enclosed)	
g.	Whether two psychiatrists independently conclude based on the examination and, on information provided by others that the person has illness of severity that the person- i) has consistently over time threatened or attempted to cause bodily harm to himself; or ii) has consistently over time behaved violently towards another person or has consistently over time caused another person to fear bodily harm from him; or iii) has consistently over time shown an inability to care for himself to a degree that places the individual at risk of harm to himself? (Enclose copies of the medical records examined by above two psychiatrists)	
h.	Whether both psychiatrists after taking into account an advanced directive, if any, certify that admission to a mental health establishment is the least restrictive care option possible under the circumstances?	
i.	Whether person continues to remain ineligible to receive care and treatment as an independent patient as the person cannot make mental healthcare and treatment decisions independently and needs very high support from his nominated representative, in making decisions? If yes, give reasons.	

j.	Whether following copies of the medical records are enclosed along with application to examine: a) the need for institutional care to person b) whether such care cannot be provided in less restrictive settings based in the community?	
k.	Whether copy of the plan for community- based treatment and the progress made or likely to be made, towards realising said plan is submitted to the review Board?	

Therefore, for the above reasons, permission for continuation of admission/readmission/discharge of person with mental illness with high supported needs beyond thirty days u/s 90 (5) may kindly be granted.

-: Certificate: -

We hereby certify that the above information's provided in the proforma are true and correct to the best of our personal knowledge and based on the clinical/medical records maintained in this medical health establishment.

Place Medical officer/mental health professional

Date

(with seal and signature)

Application submitted to the Mental health review Board u/s 93 and 103 of Mental Healthcare Act of 2017 for seeking transfer of **prisoner** with mental illness from one mental health establishment to another mental health establishment within the State or outside the State.

1.	Name of the mental health establishment seeking transfer of prisoner with mental illness.	
2.	Name of the receiving mental health establishment of prisoner with mental illness.	
3.	Name of the medical officer/mental health professional in charge of the mental health establishment receiving prisoner with mental illness and his/her contact number and e-mail id.	
4.	Date of Registration and registered number of mental health establishment seeking transfer of prisoner with mental illness.	
5.	Date of registration and registration number of mental health establishment receiving the prisoner with mental illness.	
6.	Name of the medical officer who is treating the prisoner with mental illness and his/her contact number and e-mail id.	
7.	Name of the mental health professional in charge of a mental health establishment and his/her contact number and e-mail id:	
8.	Name of the prisoner with mental illness:	
9.	Date of birth of prisoner with mental illness:	
10.	Male/Female:	
11.	Date of admission:	
12.	Department Name:	
13.	Patient No:	
14.	Whether prisoner with mental illness admitted in mental health establishment is: a) Under section 89 or b) Under section 90 or c) Under section 103?	
15.	Whether service of psychiatrist for treating the prisoner with mental illness is available in the mental health establishment which intends to transfer?	
16.	Whether mental health establishment which intends to transfer the prisoner with mental illness is equipped with necessary medical facilities for treatment?	
17.	Whether service of psychiatrist in the receiving mental health establishment for treating the prisoner with mental illness is available?	
18.	Whether mental health establishment which intends to receive the prisoner with mental	
	illness is equipped with necessary medical facilities for treatment?	

19.	What are the reasons for seeking transfer of prisoner with mental illness to other mental health establishment? (detailed reasons has to be assigned)	
20.	Whether transfer of prisoner with mental illness to another mental health establishment is ordered by the court? (enclose copy of the court order)	
21.	Whether review Board has issued any general or special order for removal of person with mental illness within the State? (If yes, enclose copy of the order)	
22.	Whether review Board with the consent of the Central Authority has issued any general or special order for transfer of prisoner with mental illness to any other State? (If yes, enclose copy of the order)	
23.	Whether intimation and reasons for transfer has been given to the prisoner with mental illness?	
24.	Whether intimation and reasons for transfer has been given to the prisoner to his nominated representative appointed u/s 14 of Mental Healthcare Act of 2017. (copy of the intimation enclosed)	
25.	Whether there is any provision for psychiatric ward in the medical wing of the prison or jail for prisoner with mental illness?	
26.	Whether quarterly report is submitted to the Board certifying therein that there are no prisoners with the mental illness in the prison or jail?	
27.	The method, modalities and procedure by which the transfer of a prisoner is to be effected. (If prescribed, enclose the copy of the same.)	

Therefore, for above reasons, permission for transfer of prisoner with mental illness may kindly be granted.

: Certificate: -

We hereby certify that, the information furnished in the above proforma are true and correct to the best of our personal knowledge and based on the clinical/medical records maintained in this medical health establishment.

Mental health professional
In charge of mental health
Establishment

Name and signature of the
jail superintendent

Place
Date

(Seal)

FORM – E
Physical Restraint Monitoring and Reporting Form
(CMHA Regulations, 2020)

Name of the Patient: **Date:**

Sex:
Age:
File No:

Provisional Diagnosis:

Date of Admission:

Indication for Physical Restraint (encircle): (1) Violence (2) Agitation (3) Aggression (4) Self-harm (5) Suicidal attempt (6) Other (specify)……

Informed Consent of the Nominated Representative taken: Yes/ No

Name and Signature of the Nominated Representative: If informed

If Consent not taken, mention the reason:

Date and Time of Physical Restraint:

Date	Time	
	From	To

Overall assessment of medical conditions of the person under physical restraint including injuries, blood supply to limbs, blood pressure, pulse, etc. or any other relevant parameter:…….

Mention the dose and frequency of medications administered during the Physical Restraint:

Medication	Dose	Route	Frequency	Total dose	Side-effects

Name, Signature and Seal
of the person in-charge of the mental health establishment:

PART 5

Basic Medical Record of all out-patients (at hospitals, nursing homes, private clinics, camps, mobile clinics, primary health care centers and other community outreach programmes, and the like matters):

(In hard copy format)

(a) Name of the mental health establishment/doctor_____

(b) Date _____

(c) Hospital registration number _____

(d) Advance Directive YES/NO

(e) Patient's Name _____

(f) Age _____Sex _____

(g) Father's/Mother's name_____ Address _____Mobile No_____

(h) Chief complaints _____

(i) Provisional diagnosis _____

(j) Treatment advised and follow-up recommendations._____

Basic Medical Record of In-Patient

a. Name of the hospital/nursing home_____
b. Date_
c. Patient's name _____
d. Father's/Mother's name_____
e. Age _Sex _____
f. Address _____
g. Patient accompanied by (Name, age and nature of relationship) _____
h. Hospital registration number_____
i. Identification marks _____
j. Nominated representative _____
k. Advanced Directive - Yes or No; If yes salient features of the content
l. Date of admission_____Date of discharge _____
m. Mode of admission (section of the Mental Healthcare Act, 2017): Independent/ Supported
n. Chief complaints
o. Summary of Medical Examination Laboratory investigations
p. Provisional/differential/ final diagnosis
q. Course in the hospital (Treatment and Progress)
r. Condition at discharge or discharge at request or leave against medical advice or person with mental illness absconding or others
s. Treatment advice at discharge
t. Follow-up recommendations

Basic Psychological Assessment Report (facilities where persons with mental illness undergoes psychological assessment):

Clinic Record no. ----------

Name: Age: Gender:

Education: Occupation: Date of testing:

Referred by: Language tested in:

Reason for referral:

IQ assessment ☐

Specific learning disability assessment ☐

Neuropsychological assessment (Specify domain if the assessment is domain specific) ☐

Personality assessment ☐

Psychopathology assessment ☐

Any other (Mention the specific domain such as interpersonal relationship)

Comments if any (may give brief detail of the referral purpose; e.g., 'the individual has mental illness and he has been referred for current psychopathology assessment as well as to ascertain the level of disability')

Brief background information (e.g., the nature of the problem, when it started, any previous assessments and like details):

Informant: ☐ Self ☐ Others ☐ Specify

Salient behavioral observations (Comment on alertness, attention, cooperativeness, affect, comprehension and any other relevant information)

Tests/ Scales administered (Standardized tests/ scales):

Salient scores (if applicable such as Intelligence Quotient, scores obtained on cognitive function tests, severity rating on psychopathology scales, disability percentage and like details)

Impression:

Recommendations:

Further assessment Specify

Therapy Specify

Any other Specify

Assessed by	Verified/ supervised by (if applicable)
Name:	Name:
Date:	Date:
Qualification:	Qualification:
Signature:	Signature:

Basic Minimum Standard Guidelines for Recording of Therapy Report (facilities where persons with mental illness are provided with therapy for any mental health problem)

Minimum Basic Standard Guidelines for Recording of Therapy

(Name of the Institute/Hospital/Centre with address)

Clinic record no._____

THERAPIST SESSION NOTES

Patient name:

Age:

Gender:

Psychiatric diagnosis:

Session number and date:	**Duration of session:**	**Session Participants:**
Therapy method: **Individual** **Couple/Family** **Group** **Other _**	**Objectives of the session:** **1.** **2.** **3.** **4.**	

Key issues/themes discussed: (Psychosocial stressors/Interpersonal problems/Intrapsychic conflicts/Crisis situations/Conduct difficulties/Behavioral difficulties/ Emotional difficulties/ Developmental difficulties/ Adjustment issues/ Addictive behaviours/ Others).

Therapy techniques used:

Therapist observations and reflections:

Plan for next session:

Date for next session:

Therapist

Name:

Date:

Qualification:

Signature:

Supervised by (if applicable)

Name:

Date:

Qualification:

Signature:

PART 6

APPLICATION FOR ASSSESSMENT/ADMISSION OF ANY PERSON FOUND WANDERING AT LARGE WITH MENTAL ILLNESS

(Application u/s 100 of MHCA, 2017)

1.	**Particulars of the person found wandering at large with mental illness**	
	a) Name:	
	b) Fathers name:	
	c) Age:	
	d) Address: (If any)	
	e) Male/Female:	
	f) Contact number: (If any)	
2.	**Particulars of the police station and duties performed by the Police Officer:**	
	a) Police station	
	b) Contact number:	
	c) E-mail- id:	
	d) Officer in charge of the police station (Name, designation, ID number, contact number, email id)	
	e) Date and time of taking homeless and wandering person for protection.	
	f) Date and time of taking such person to the nearest public health establishment:	
	g) Place where person found at large:	
	h) Whether first information report (FIR) of missing person is lodged?	
	i) Whether station house officer (SHO) has made any efforts to trace the family of such person and informed the family aboutwhere abouts?	

Therefore, for the above reasons the applicant requests for assessment/admission of the patient…….
Hospital id .....as early as possible.

-: Certificate: -

I, hereby certify that the information furnished above are true and correct to the best of my personal knowledge.

Place

Date

Signature

Name

Police Station

Police ID No.

Request for appointment of nominated representative of the **person with mental illness who is HOMELESS or FOUND WANDERING AT LARGE (Section 100, 14, 15 & 17).**

1.	**Particulars of the person found homeless or wandering at large with mental illness:**	
	a) Name:	
	b) Fathers name:	
	c) Age:	
	d) Address: (If any)	
	e) Male/Female:	
	f) Contact number: (If any)	
2.	**Particulars of public health establishment:**	
	a) Name:	
	b) Address:	
	c) Contact number:	
	d) E-mail-id:	
	e) Name of the medical officer who has arranged the assessment of the person and the needs of the person with mental illness:	
	f) Contact number of medical officer:	
	g) If medical officer in charge of public health establishment, after assessment, found such person suffering from mental illness, whether such person is admitted for the treatment and reported the same matter to the Board as required u/s 87 or 89 of the Act as the case may be?	
3.	**Particulars of a Government establishment for homeless persons:**	
	a) Name:	
	b) Name of the administrator:	
	c) Contact number:	
	d) E-mail id:	
	e) Address:	
	f) Name of the doctor/psychiatrist: (If any)	
4.	**Particulars of the police station and duties performed by the Police Officer:**	
	a) Name/Address:	
	b) Contact number:	
	c) E-mail- id:	
	d) Date of taking homeless and wandering person for protection.	
	e) Date and time of taking such person to the nearest public health establishment:	
	f) Place where person found at large:	
	g) Officer in charge of a police station:	
	h) Whether grounds of taking into protection is informed to such person or his nominated representative?	

	i) Whether such person is taken by police officer to the nearest public health establishment within 24 hours for assessment of person's health care needs?	
	j) Whether such person taken into protection is detained in the police lockup or prison?	
	k) Whether first information report (FIR) of missing person is lodged?	
	l) Whether station house officer (SHO) has made any efforts to trace the family of such person and informed the family about where abouts?	
	m) What is the report of police officer about the such person's residence?	
5.	Whether the medical officer after collecting the above authentic information has filed this application to the Board for appointing a nominative representative of a person with mental illness u/s 14 (4) and 15 of the Mental Healthcare Act of 2017?	

Therefore, the undersigned medical officer/ mental health professional in charge of public health establishment for above reasons, prays for seeking order of appointment of nominated representative of the person with mental illness who is homeless or found wandering at large.

Certificate: -

I hereby certify that, the information furnished in the above proforma are true and correct to the best of my personal knowledge and on the clinical/medical records maintained in this medical health establishment and based on the information furnished by the police officer.

Place: Medical office/Mental health professional,
Date: in charge of mental health establishment.

(with seal and signature)

Application submitted for filing of FIR by police under section 100 of MHCA 2017 of the **person with mental illness who is <u>HOMELESS</u> or <u>FOUND WANDERING AT LARGE</u> (Section 100 of the Act).**

1.	**Particulars of the person found homeless or wandering at large with mental illness:**	
	a) Name:	
	b) Fathers name:	
	c) Age:	
	d) Address: (If any)	
	e) Male/Female:	
	f) Contact number: (If any)	
2.	**Particulars of public health establishment:**	
	a) Name:	
	b) Address:	
	c) Contact number:	
	d) E-mail-id:	
	e) Name of the medical officer who has arranged the assessment of the person and the needs of the person with mental illness:	
	f) Contact number of medical officer:	
	g) If medical officer in charge of public health establishment, after assessment, found such person suffering from mental illness, whether such person is admitted for the treatment and reported the same matter to the Board as required u/s 87 or 89 of the Act as the case may be?	
3.	**Particulars of the police station**	
	a) Name/Address:	
	b) Contact number:	
	c) E-mail- id:	

Therefore, the undersigned medical officer/ mental health professional in charge of public health establishment for above reasons, prays for filing of FIR by police under section 100 of MHCA 2017 of the person with mental illness who is homeless or found wandering at large.

<u>Certificate: -</u>

I hereby certify that, the information furnished in the above proforma are true and correct to the best of my personal knowledge and on the clinical/medical records maintained in this medical health establishment and based on the information furnished by the police officer.

Place:
Date:

Medical office/Mental health professional,
in charge of mental health establishment.

(with seal and signature)

SECTION 100 (MHCA, 2017)

RESPONSIBILITIES OF OTHER AGENCIES

Duties of police officers in respect of persons with mental illness.

100. (*1*) Every officer in-charge of a police station shall have a duty—

(*a*) to take under protection any person found wandering at large within the limits of the police station whom the officer has reason to believe has mental illness and is incapable of taking care of himself; or

(*b*) to take under protection any person within the limits of the police station whom the officer has reason to believe to be a risk to himself or others by reason of mental illness.

(*2*) The officer in-charge of a police station shall inform the person who has been taken into protection under sub-section (*1*), the grounds for taking him into such protection or his nominated representative, if in the opinion of the officer such person has difficulty in understanding those grounds.

(*3*) Every person taken into protection under sub-section (*1*) shall be taken to the nearest public health establishment as soon as possible but not later than twenty-four hours from the time of being taken into protection, for assessment of the person's healthcare needs.

(*4*) No person taken into protection under sub-section (*1*) shall be detained in the police lock up or prison in any circumstances.

(*5*) The medical officer in-charge of the public health establishment shall be responsible for arranging the assessment of the person and the needs of the person with mental illness will be addressed as per other provisions of this Act as applicable in the particular circumstances.

(*6*) The medical officer or mental health professional in-charge of the public mental health establishment if on assessment of the person finds that such person does not have a mental illness of a nature or degree requiring admission to the mental health establishment, he shall inform his assessment to the police officer who had taken the person into protection and the police officer shall take the person to the person's residence or in case of homeless persons, to a Government establishment for homeless persons.

(*7*) In case of a person with mental illness who is homeless or found wandering in the community, a First Information Report of a missing person shall be lodged at the concerned police station and the station house officer shall have a duty to trace the family of such person and inform the family about the whereabouts of the person.