fraserhealth

DIRECTOR AUTHORIZATION CHECKLIST
REGIONAL MENTAL HEALTH ACT

Instructions: This is an **optional** Fraser Health form for B.C. *Mental Health Act* (MHA) director or director-delegate to help appraise the legal and quality criteria when asked to authorize involuntary admission and treatment. Follow the checklist when reviewing MHA forms and place this form on the person's chart.

Form 4.1 First Medical Certificate (Involuntary Admission)		
☐	Medical examination completed within the past 14 days prior to authorization	
☐	Decisions and form completed by fully licensed physician or nurse practitioner	
☐	Person's full legal first and last name is provided	
☐	Evidence of a mental illness and/or condition	e.g., psychiatric condition; not abbreviated
☐	Evidence the illness and/or condition is seriously impairing the person's ability to interact appropriately with the environment and/or people	e.g., signs, symptoms, impacts on their life, risks and/or harms, what hospital offers for these etc.
☐	Evidence the person needs the unique care, supervision, control offered by an involuntary hospital admission to prevent further deterioration and/or protect self and others	
☐	Evidence the person cannot be voluntarily admitted	e.g., is not capable, won't talk about it, refused etc.
☐	Dates appear accurate and in correct format	
☐	Medical practitioner's signature is present where needed	
☐	Where the form was completed clearly stated along with address	name or common abbreviation (e.g., SMH)
☐	Authorizing admission (section 2) site is a designated facility (e.g., ARH, BH, CGH, LMH, PAH, RCH, RMH, SMH)	
☐	Ensure forms are legible so patient or external advocate understand	e.g., use plain everyday language, free of medical jargon, and complex medical terms
☐	Required: print full legal name of authorizing director or director-delegate	
☐	Required: signature of authorizing director or director-delegate	
☐	Required date and director director-delegate authorized	
Form 4.2 Second Medical Certificate (Involuntary Admission)		
☐	Form 4.1 Section 1 and Section 2 are fully completed as legally required.	
☐	Patient/person's full legal first and last name is provided and matches First Medical Certificate - Form 4.1	
☐	Completed within 48 hours of Section 2 of the Form 4.1 being authorized	
☐	Decisions and form completed by fully licensed physician	
☐	Medical examination completed and documented within 48 hours of admission to a designated facility	
☐	Evidence of a mental illness and/or condition	e.g., psychiatric condition; not abbreviated
☐	Evidence the illness and/or condition is seriously impairing the person's ability to interact appropriately with the environment and/or people	e.g., signs, symptoms, impacts on their life, risks and/or harms, what hospital offers for these etc.
☐	Evidence the person needs the unique care, supervision, control offered by an involuntary hospital admission to prevent further deterioration and/or protect self and others	
☐	Evidence the person cannot be voluntarily admitted	e.g., is not capable, won't talk about it, refused etc.
☐	Physicians signature is present where needed	
☐	Site is a designated facility (e.g., ARH, BH, CGH, LMH, PAH, RCH, RMH, SMH)	
☐	Ensure forms are legible so patient or external advocate understand	e.g., use plain everyday language, free of medical jargon, and complex medical terms
☐	Required: print full legal name of authorizing director or director-delegate	
☐	Required: signature of authorizing director or director-delegate	
☐	Required: date and time director or director-delegate authorized	

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Consent for Treatment (Involuntary Patient) (*Mental Health Act* - Form 5)		
☐	Patient name matches name on the Medical Certificate (Involuntary Admission) *(Mental Health Act* - Form 4.1 and 4.2)	
☐	Treatments are for a mental illness and/or condition	nutrition interventions for eating disorder allowed
☐	Plan is patient specific and individualized to the patient's unique needs	no boiler plate (e.g. cut and paste) descriptions or stamps
☐	Plan describes the routine treatment	e.g., lab categories; medication classes; talk therapies etc.
☐	Explicitly state higher risk treatments	e.g., Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), seclusion, restraints etc.
☐	Explicitly state new or uncommon treatments	e.g., Psychedelics, etc.
☐	Physician name and position and/or title is complete	first initial, full last name and position or title
☐	Physician sign at bottom of section B	
☐	Director or delegate write your name at section B top and bottom	minimum first initial, full last name
☐	Director or delegate write matching patient name	same as on Form 4 or 4.1
☐	Director or delegate write location name	name or common abbreviation (e.g., SMH)
☐	Director or delegate write your position or title	role with delegation e.g., PCC, PLN etc.
☐	Director or delegate write the date and time	
☐	Director or delegate signature	
☐	Legible so a client or external advocate can read it	e.g. use plain everyday language, free of medical jargon, and complex medical terms
Notification to Involuntary Patient of Rights Under the *Mental Health Act* (*Mental Health Act* Form 13)		
Mandatory MHA Admission Form, Any Fraser Health Staff Member may complete		
☐	Complete form within 24 hours of admission	
☐	Patient name matches name on the Medical Certificate (Involuntary Admission) *(Mental Health Act* - Form 4. 1)	
☐	Includes name and address of facility	
☐	Staff name on form (e.g., name of person who provided information)	first name, last initial acceptable
Nomination of Near Relative *(Mental Health Act* - Form 15)		
Mandatory MHA Admission Form, Any Fraser Health Staff Member may complete		
☐	Complete form within 24 hours	Staff member signature always required
☐	Patient name matches name on the Medical Certificate (Involuntary Admission) *(Mental Health Act* - Form 4.1)	
☐	Person's relationship to patient box checked	
☐	Name, address and phone number of near relative is included	
☐	Date form is completed is documented	
☐	Includes name and address of facility	
Notification to Near Relative (Admission of Involuntary Patient or Patient Under 16 years) (*Mental Health Act* - Form 16)		
☐	Form present and completed within 24 hours	
☐	Includes near relative name, address and phone number	
☐	Patient name matches name on the Medical Certificate (Involuntary Admission) (*Mental Health Act* - Form 4.1)	
☐	Select involuntary patient or patient under 16 years	
☐	Includes name and address of designated facility	
☐	Includes director or delegate name	first initial, last name acceptable
☐	Director or delegate signature	
☐	Date form is completed is documented	
☐	Community Legal Assistance Society (CLAS) and legal services information is complete	
☐	Complete and Mail any additional **Form 16** to any: Power of Attorney (POA), representative, committee or person designate deems necessary	
☐	Hand delivered or sent using Canada Post registered mail	

[1] This checklist is not a MHA legal form or requirement for involuntary admission or treatment. It will not be kept as part of the permanent health record.