Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FORM 19 – *Northwest Territories Mental Health Act*

APPLICATION TO REVIEW BOARD

Please complete this application form if you would like to request a hearing by the Mental Health Act Review Board (MHARB).

If you need help in completing this application, you can ask a friend, family member, or health professional for assistance, or contact the Northwest Territories Mental Health Act Review Board at 867-767-9061 extension 49177.

APPLICANT INFORMATION

Name		
Street Address/ PO Box	Community	Postal Code
Email Address	Telephone Number(s)	
Name of Patient/Person Subject to Certificate (if different from above)		

I, _____, am applying to the Mental Health Act Review Board.
(Name of Applicant)

I am the (please check the most appropriate option):

- ☐ Patient or person subject to a certificate

OR

- ☐ Patient's substitute decision maker
- ☐ Person who has lawful custody/authority of the patient who is a minor
- ☐ Legal guardian of the patient
- ☐ Agent of the patient, who is under a personal directive
- ☐ Nearest relative of the patient (please specify): _____
- ☐ Patient's attending medical practitioner
- ☐ Director of the designated facility were the patient is admitted or where a certificate has been filed
- ☐ Public Trustee
- ☐ Other person seeking approval to apply to the Review Board (please specify your relationship to the patient/person):

_____

I am applying for the following order(s) or review(s) (please check all that apply):

ORDER BEING REQUESTED *Note: the Review Board may make any order it believes is necessary*

- ☐ Cancel *Certificate of Involuntary Assessment* to release person back to community
- ☐ Cancel *Certificate of Involuntary Admission* or *Renewal Certificate* to release patient back to community
- ☐ Cancel *Certificate of Mental Incompetence* so patient can make own decisions about their estate
- ☐ *Treatment Decision Certificate:*
  - ☐ Cancel certificate because I believe the patient can make their own treatment decisions
  - ☐ Issue certificate because I believe the patient cannot make their own treatment decisions
- ☐ Designating a different substitute decision maker (please indicate designation being requested):
  - ☐ _____ (please specify)
  - ☐ A different person at the discretion of the Review Board
- ☐ Cancel *Certificate Authorizing Transfer of Involuntary Patient to Facility Outside the Northwest Territories* so patient remains at designated facility in the NWT
- ☐ Cancel *Short Term Leave Certificate* so patient must return to designated facility for treatment and care
- ☐ Cancel *Assisted Community Treatment Certificate* so patient must return to designated facility for treatment and care
- ☐ Cancel *Certificate Requiring Patient to Attend Mandatory Assessment at Health Facility* so patient continues Assisted Community Treatment without assessment
- ☐ Amend *Assisted Community Treatment Certificate* and/or terms and conditions in *Community Treatment Plan* as follows (please specify):
  - ☐ _____
  - _____
  - ☐ Amendments as deemed necessary by Review Board
- ☐ Cancel *Certificate Cancelling Assisted Community Treatment* so patient continues Assisted Community Treatment
- ☐ Authorize medical practitioner to provide treatment that has been refused by patient or substitute decision maker
- ☐ Direct psychosurgery be performed on patient who has agreed to the procedure
- ☐ Remove or modify the following limits placed on the patient's rights (please specify):

_____

_____

These are my reasons for applying:

Please attach any information or documents for the Mental Health Act Review Board to consider in reviewing this application.

Printed Name of Applicant	X PLEASE PRINT FORM TO SIGN Signature	Date (DD-MM-YYYY)

TO BE COMPLETED BY MENTAL HEALTH ACT REVIEW BOARD

Date application received by the MHARB (DD-MM-YYYY):

Please fax or email this application to:

Mental Health Act Review Board
5015-49th St., NGB-6th Floor
Box 1320
Yellowknife NT X1A 2L9
Phone: 867-767-9061 ext. 49177
Fax: 867-873-0143
Email: MHAct_ReviewBoard@gov.nt.ca

The personal health information on this form is being collected under the authority of the *Mental Health Act*. It is protected by the privacy provisions under the *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about this form, please contact the Clinical Mental Health Program Specialist at 867-767-9061 ext. 49164 or mentalhealth_act@gov.nt.ca