

**Section 7 – guardianship application by an approved mental health professional**

**PART 1**

*(To be completed by the approved mental health professional)*

To the *(name of local social services authority)*

I *(PRINT your full name and address)*

apply for the reception of

*(PRINT full name and address of patient)*

into the guardianship of

*(PRINT full name and address of proposed guardian)*

in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of *(name of local social services authority)*

and am approved to act as an approved mental health professional for the purposes of the Act by  
*(delete as appropriate)*

that authority

*(name of local social services authority that approved you, if different.)*

*Complete the following where consultation with the nearest relative has taken place.*

*Complete (a) or (b) as applicable and delete the other.*

(a) I have consulted

*(PRINT full name and address)*

who to the best of my knowledge and belief is the patient's nearest relative within the meaning of the Act;

(b) I have consulted

*(PRINT full name and address)*

who I understand has been authorised by a county court / the patient's nearest relative to exercise the functions under the Act of the patient's nearest relative. *(Delete the phrase which does not apply)*

That person has not notified me or the local social services authority on whose behalf I am acting that he or she objects to this application being made.

*Complete the following where the nearest relative has not been consulted.*

*Delete whichever two of (a), (b) and (c) do not apply.*

(a) I have been unable to ascertain who is this patient's nearest relative within the meaning of the Act,

OR

(b) to the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act,

OR

(c) *(PRINT full name and address)*

is

(i) this patient's nearest relative within the meaning of the Act,

(ii) authorised to exercise the functions of this patient's nearest relative under the Act,

*(Delete either (i) or (ii))*

but in my opinion it is not reasonably practicable / would involve unreasonable delay *(delete as appropriate)* to consult that person before making this application, because –

*(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)*

The remainder of Part 1 of this form must be completed in all cases.

I last saw the patient on

/ / (date)

which was within the period of 14 days ending on the day this application is completed.

\* The patient's date of birth is

/ / (date)

OR

\* I believe the patient is aged 16 years or over.

(\* Delete the phrase which does not apply.)

This application is founded on two medical recommendations in the prescribed form.

*If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient –*

*(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)*

Signed

Date

/ /

**PART 2\***

*(\* Complete only if proposed guardian is not a local social services authority)*

*(To be completed by the proposed guardian)*

My full name and address is as entered in Part 1 of this form and I am willing to act as the guardian of the above named patient in accordance with Part 2 of the Mental Health Act 1983.

Signed

Date

/ /