

PART 1

(To be completed by the responsible clinician or nominated medical attendant)

To *(name of guardian)*

(name of responsible local social services authority if it is not the guardian)

I examined *(PRINT full name and address of patient)*

on

(date)

The patient is subject to guardianship for a period ending on

(date authority for guardianship is due to expire)

In my opinion,

- (a) this patient is suffering from mental disorder of a nature or degree which warrants the patient's reception into guardianship under the Act,

AND

- (b) it is necessary
- (i) in the interests of the welfare of the patient
 - (ii) for the protection of other persons
- (delete (i) or (ii) unless both apply)*

that the patient should remain under guardianship under the Act.

My reasons for these opinions are:

(Your reasons should cover both (a) and (b) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; and explain why the patient cannot appropriately be cared for without powers of guardianship.)

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

Signed

* Responsible clinician

* Nominated medical attendant

(Delete whichever does not apply.)*

PRINT NAME

Date

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PART 2

(To be completed on behalf of the responsible local social services authority)

This report was received by me on behalf of the local social services authority on

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(date)

Signed

on behalf of the local social services authority

PRINT NAME

Date

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