

**Section 3 – joint medical recommendation for admission for treatment**

We, registered medical practitioners, recommend that  
(*PRINT full name and address of patient*)

be admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I (*PRINT full name and address of first practitioner*)

last examined this patient on

/ / (date)

- \* I had previous acquaintance with the patient before I conducted that examination.
- \* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(\* Delete if not applicable)

I (*PRINT full name and address of second practitioner*)

last examined this patient on

/ / (date)

- \* I had previous acquaintance with the patient before I conducted that examination.
- \* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(\* Delete if not applicable)

In our opinion,

- (a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

- (b) it is necessary
  - (i) for the patient's own health
  - (ii) for the patient's own safety
  - (iii) for the protection of other persons(delete the indents not applicable)

that this patient should receive treatment in hospital,

AND

- (c) such treatment cannot be provided unless the patient is detained under section 3 of the Act,

because – *(Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.)*

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

We are also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all the other circumstances of the case, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):—

*(Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.)*

Signed

Date

/ /

Signed

Date

/ /

**NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.**



**Section 4 – medical recommendation for emergency admission for assessment****THIS FORM IS TO BE USED ONLY FOR AN EMERGENCY APPLICATION**I (*PRINT name and address of medical practitioner*)

a registered medical practitioner, recommend that

(*PRINT full name and address of patient*)

be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on

/

/

(date)

at

:

(time)

\* I had previous acquaintance with the patient before I conducted that examination.

\* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(\* *Delete if not applicable*)

I am of the opinion,

- (a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

**AND**

- (b) this patient ought to be so detained
- (i) in the interests of the patient's own health
  - (ii) in the interests of the patient's own safety
  - (iii) with a view to the protection of other persons,
- (*delete the indents not applicable*)

**AND**

- (c) it is of urgent necessity for the patient to be admitted and detained under section 2 of the Act.

My reasons for these opinions are: *(Your reasons should cover (a), (b) and (c) 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 ought to be admitted to hospital urgently and why informal admission is not appropriate.)*

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

Compliance with the provisions of Part 2 of the Act relating to applications under section 2 would involve undesirable delay, because – *(Say approximately how long you think it would take to obtain a second medical recommendation and what risk such a delay would pose to the patient or to other people.)*

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

Signed

Date

/ /

Time

:

**Section 4 – emergency application by an approved mental health professional for admission for assessment****THIS FORM IS TO BE USED ONLY FOR AN EMERGENCY APPLICATION**

To the managers of *(name and address of hospital)*

I *(PRINT your full name and address)*

apply for the admission of

*(PRINT full name and address of patient)*

for assessment 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)*

I last saw the patient on

/ / (date) at : (time)

which was within the last 24 hours.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

In my opinion it is of urgent necessity for the patient to be admitted and detained under section 2 of the Act and compliance with the provisions of Part 2 of the Act relating to applications under that section would involve undesirable delay.

This application is founded on a medical recommendation in the prescribed form.

*If the medical practitioner did not have previous acquaintance with the patient before making the recommendation, 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

/

/

Time

:



**Section 3 – application by an approved mental health professional for admission for treatment**

To the managers of *(name and address of hospital)*

I *(PRINT your full name and address)*

apply for the admission of *(PRINT full name and address of patient)*

for treatment 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) 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.
- (b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.
- (c) I understand that (*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 this form must be completed in all cases.

I saw the patient on

/ / (date)

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

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

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

/ /

These materials are intended for use in the laboratory and are not to be used for any other purpose. The information contained herein is for informational purposes only and is not to be used for any other purpose.

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**Section 2 – joint medical recommendation for admission for assessment**

We, registered medical practitioners, recommend that  
(*PRINT full name and address of patient*)

be admitted to a hospital for assessment in accordance with Part 2 of the Mental Health Act 1983.  
I (*PRINT full name and address of first practitioner*)

last examined this patient on  
/ / (date)

- \* I had previous acquaintance with the patient before I conducted that examination.
- \* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(\* Delete if not applicable)

I (*PRINT full name and address of second practitioner*)

last examined this patient on  
/ / (date)

- \* I had previous acquaintance with the patient before I conducted that examination.
- \* I am approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(\* Delete if not applicable)

In our opinion,

- (a) this patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period,

AND

- (b) ought to be so detained
  - (i) in the interests of the patient's own health
  - (ii) in the interests of the patient's own safety
  - (iii) with a view to the protection of other persons.

(Delete the indents not applicable)

Our 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; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.)*

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

Signed

Date

/ /

Signed

Date

/ /

**NOTE: AT LEAST ONE OF THE PRACTITIONERS SIGNING THIS FORM MUST BE APPROVED UNDER SECTION 12 OF THE ACT.**

**Form A2** Regulation 4(1)(a)(ii)**Mental Health Act 1983****Section 2 – application by an approved mental health professional for admission for assessment**To the managers of (*name and address of hospital*)I (*PRINT your full name and address*)apply for the admission of (*PRINT full name and address of patient*)

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

I am acting on behalf of (*PRINT 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 if you know who the nearest relative is.

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

(a) To the best of my knowledge and belief (*PRINT full name and address*)

is the patient's nearest relative within the meaning of the Act.

(b) I understand that (*PRINT full name and address*)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*)I have / have not yet\* informed that person that this application is to be made and of the nearest relative's power to order the discharge of the patient. (\* *Delete the phrase which does not apply*)

continue overleaf



Complete the following if you do not know who the nearest relative is. Delete (a) or (b).

- (a) I have been unable to ascertain who is the patient's nearest relative within the meaning of the Act.
- (b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

The remainder of the 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.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

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

/ /