

6

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.....

Signature: .....

(head of national department)

Date: .....

Place: .....

[Copy to be sent back to head of health establishment]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 14

## DEPARTMENT OF HEALTH

## DECISION BY REVIEW BOARD CONCERNING –

- (a) assisted mental care, treatment and rehabilitation [section 28(3) of the Act];
- (b) appeal against decision of head of health establishment concerning assisted care, treatment and rehabilitation [section 29(2) of the Act];
- (c) further involuntary care, treatment and rehabilitation on an inpatient basis [section 34(7) of the Act]; or
- (d) appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation [section 35(2) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

.....

The Review Board of .....

(name of review Board)

have considered documentation and issues relevant to:

**Application for assisted- / involuntary\* care, treatment and rehabilitation of the above user.**

The Review Board have considered (inter alia) whether:

- (a) the user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services.
- (b) the user is suffering from a mental illness or severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for his / her health and safety or the health and safety of others.
- (c) the use is willing to receive care, treatment and rehabilitation services.
- (d) the user is likely to inflict serious harm on him / herself or others.

- (e) care, treatment and rehabilitation is necessary for the user's financial interest and reputation.
- (f) the user's right to movement, privacy and dignity will be unnecessarily restricted.

**Application to appeal against decision of head of health establishment on assisted- / involuntary\* care, treatment and rehabilitation**

The Review Board have requested / provided the opportunity for the following to make oral or written representations on the merits of the request:

- (a) applicant
- (b) appellant
- (c) independent mental health care practitioner(s)
- (d) head of health establishment
- (e) others

The Review Board concludes that\* -

- (a) the user should not receive care, treatment and rehabilitation services without his / her consent either as an assisted- or involuntary user.
- (b) the user should receive care, treatment and rehabilitation services as an assisted user.
- (c) the user should receive involuntary care, treatment and rehabilitation services as an inpatient.
- (d) the user should receive involuntary care, treatment and rehabilitation services as an outpatient.

Reasons for this decision:

.....  
 .....  
 .....  
 .....

Print initials and surname .....

Signature: .....

(chair of Review Board)

Date: .....

Place: .....

[Copy to be sent (as applicable) to: applicant, appellant, head of health establishment concerned, head of provincial department and High Court Judge]



MHCA 15

## DEPARTMENT OF HEALTH

**APPEAL TO REVIEW BOARD AGAINST DECISION OF HEAD OF HEALTH  
ESTABLISHMENT ON ASSISTED- OR INVOLUNTARY MENTAL HEALTH  
CARE, TREATMENT AND REHABILITATION  
[Sections 29(1) and 35(1) of the Act]**

**Details of user**

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

.....

Is the user the applicant? Yes ☐ No ☐**If No to the above:**

Surname of appellant: .....

First name(s) of appellant: .....

Residential address: .....

.....

.....

.....

Relationship between applicant and mental health care user: (mark with a cross)

 Spouse ☐  
 Next of kin ☐

 Partner ☐  
 Parent ☐

 Associate ☐  
 Guardian ☐

Grounds for the appeal:

.....  
.....  
.....  
.....  
.....  
.....

Facts on which the appeal is based:

.....  
.....  
.....  
.....  
.....  
.....

Signature: .....

(appellant)

Date: .....

Place: .....



MHCA 16

## DEPARTMENT OF HEALTH

**ORDER BY HIGH COURT FOR FURTHER TREATMENT AND  
REHABILITATION / DISCHARGE OF AN INVOLUNTARY USER ON AN  
INPATIENT BASIS  
[Section 36(c) of the Act]**

In the High Court of South Africa. .... Division

In the matter of .....

(involuntary user's name)

at present being confined at .....

(name of health establishment)

as an involuntary user following the decision of the Review Board under sections 34(7) or  
35(4) of the Act dated the .....

**IT IS HEREBY ORDERED**

That the said .....

(name of user)

- (a) (i) be further kept / provided with care, treatment and rehabilitation services until the  
said user has recovered or is otherwise legally discharged;
- (ii) the financial affairs of the said user be managed and administered according to  
the provisions of Chapter VIII of the Act; or
- (b) the said user be discharged immediately.

By order of the Honourable Justice .....

Date: .....

Place: .....

Registrar: .....

[Copy to be sent to applicant, appellant, Review Board and head of health establishment]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 17

DEPARTMENT OF HEALTH

DECISION BY REVIEW BOARD FOLLOWING PERIODICAL REPORT OF  
REVIEW ON ASSISTED- OR INVOLUNTARY MENTAL HEALTH CARE USERS  
AND MENTALLY ILL PRISONERS  
[Sections 30(4), 37(4) or 55(2)(a) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Health establishment concerned .....

(name of health establishment)

The Review Board of ..... have considered

(name of Review Board)

documentation and issues relevant to the periodic review of the above user.

The Review Board have considered (inter alia) whether:

- (a) the user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services.
- (b) the user is suffering from a mental illness or severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for his / her health and safety or the health and safety of others.
- (c) the user is willing to receive care, treatment and rehabilitation services.
- (d) the user is likely to inflict serious harm on him / herself or others.
- (e) care, treatment and rehabilitation is necessary for the user's financial interest and reputation.
- (f) the user's right to movement, privacy and dignity will be unnecessarily restricted.

The Review Board have requested the following people to make oral or written representations:

- (a) applicant
- (b) independent mental health care practitioner(s)
- (c) head of health establishment

(d) others

The Review Board concludes that:

- (a) the user should cease to receive care, treatment and rehabilitation services unless with his / her consent as a voluntary mental health care user.
- (b) the user should continue to receive care, treatment and rehabilitation services as an assisted user.
- (c) the user should continue to receive involuntary care, treatment and rehabilitation services as an inpatient.
- (d) the user should continue to receive involuntary care, treatment and rehabilitation services as an outpatient.
- (e) the user should be transferred from being an involuntary inpatient to being an involuntary outpatient.

Reasons for this decision:

.....  
.....  
.....  
.....

Print initials and surname .....

Signature: .....

(Chair of Review Board)

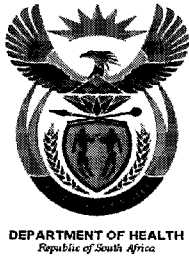
Date: .....

Place: .....

[Copies to be sent in the case of:

- assisted or involuntary user to user, applicant, head of health establishment concerned and head of provincial department;
- mentally ill prisoner, administrator (if appointed) head of health establishment concerned, relevant magistrate, head of relevant prison and head national department..





MHCA 18

## DEPARTMENT OF HEALTH

**SUMMONS TO APPEAR BEFORE A REVIEW BOARD**  
**[Sections 29(2)(a) and 35(2)(c) of the Act]**

.....

(name of person summoned and his or her address)

is hereby summoned to appear at ..... (place)

on ..... (date and time) before the Review Board of

..... (name of health establishment)

to give evidence in respect of .....

.....

.....

.....

(if the person summoned is to produce any book, record, document or thing, add)

and you are hereby directed to produce:

.....

.....

.....

.....

(specify the book, record, document or thing concerned)

Given under the hand of the chairperson of the Review Board, this ..... day

of .....

Signature: .....

(chairperson of Review Board)



MHCA 19

## DEPARTMENT OF HEALTH

REQUEST BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD TO  
TRANSFER -

- (a) an assisted- or involuntary mental health care user in terms of section 39(1) of the Act to maximum security facilities;  
 (b) a State patient between designated health establishments in terms of section 43 of this Act; or  
 (c) a mentally ill prisoner between designated health establishments in terms of section 54(2) of the Act.

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Health establishment from where the request is made: .....

State clearly the reason(s) for the request: .....

.....

.....

.....

.....

.....

Has the user previously absconded or attempted to abscond? Yes ☐ No ☐

Explain circumstances:

.....

.....

.....

.....

.....

Has the user inflicted harm on others at the health establishment? Yes ☐ No ☐

Explain circumstances:

.....

.....

.....

.....

.....

In your opinion is the user likely to inflict harm on others in the health establishment

Yes ☐ No ☐

Explain:

.....

.....

.....

.....

.....

Other reason(s) for making the request:

.....

.....

.....

.....

.....

Print initials and surname .....

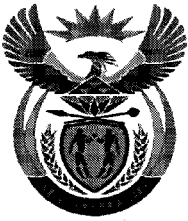
Signature: .....

(head of health establishment)

Date: .....

Place: .....

MHCA 20

DEPARTMENT OF HEALTH  
Republic of South Africa

## DEPARTMENT OF HEALTH

## ORDER BY REVIEW BOARD TO TRANSFER -

(a) an assisted- or involuntary mental health care user in terms of section 39(4) of the Act to maximum security facilities;

(b) a State patient between designated health establishments in terms of section 43(3) of this Act; or

(c) a mentally ill prisoner between designated health establishments in terms of section 54(2) of the Act.

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Health establishment making the request: .....

The Review Board of .....

(name of Review Board)

have considered documentation and representation relevant to the transfer of the above user to a maximum security facility.

The Review Board have considered *inter alia* that:

- (a) the transfer is not being done in order to punish the user.
- (b) The transfer is warranted taking cognizance of the mental health status of the user.

Reason(s) for transfer:

.....

.....

.....

.....  
.....  
.....  
.....

The above user must be transferred to a health establishment with maximum security facilities.

Print initials and surname .....

Signature: .....

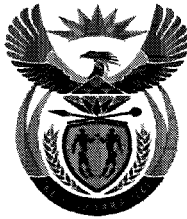
(chairperson of Review Board)

Date: .....

Place: .....

[Copy to:

- with respect to assisted- and involuntary mental health care users, this order must be sent to the head of the provincial department.
- With respect to State patients and mentally ill prisoners the order must be sent to the head of the national department]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 21

## DEPARTMENT OF HEALTH

**NOTICE OF TRANSFER OF STATE PATIENT OR MENTALLY ILL PRISONER**  
[sections 43(8) or 54(6) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

The above State patient or mentally ill prisoner has been transferred:

From: .....  
(name of health establishment)

To: .....  
(name of health establishment)

Reasons for transfer: .....  
.....  
.....  
.....

Date of transfer: .....

Print initials and surname .....

Signature: .....  
(person effecting the transfer)

Date: .....

Place: .....

[Copy:

- In respect of State patient to be sent to official *curator ad litem* and national department.
- In respect of mentally ill prisoner to be sent to the head of the relevant prison, Review Board and national department as well as to the administrator where appointed]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 22

DEPARTMENT OF HEALTH

**HANDING OVER CUSTODY BY THE SOUTH AFRICAN POLICE SERVICES  
(SAPS) OF A PERSON SUSPECTED OF BEING MENTALLY ILL OR  
SEVERELY OR PROFOUNDLY INTELLECTUALLY DISABLED AND LIKELY TO  
INFLECT SERIOUS HARM  
[Section 40(1) of the Act]**

I .....

(print rank, initials and surname of member of SAPS)

have reason to believe from personal observation or from information obtained from a mental health care professional that .....

.....  
.....  
.....

(user's name or description if no name is available)

is suffering from a mental disability and is likely to inflict serious harm.

I have apprehended the person and have brought him / her to .....

.....

(name of health establishment)

for assessment by a mental health care practitioner.

Name and address of next of kin (where possible)

.....  
.....  
.....

I hereby hand over custody of the said person to the head of the health establishment or his / her designate.

Signature: .....

(member of SAPS)

Date: .....

Time: .....

Place: .....

2

I .....  
(name of head of health establishment or designated person)  
accept custody of .....  
(name of user or description if no name is available)  
at the .....  
(name of health establishment)

The user's physical condition is as follows (describe any bruises, lacerations etc):

.....  
.....  
.....  
.....  
.....

The user will be assessed by two mental health care practitioners in terms of section 33 of the Act.

Signature: .....  
(head of health establishment or designated person)

Date: .....

Time: .....

Place: .....

[Copy to be sent to SAPS to confirm in writing the physical condition as stated above during handing over of custody]

The SAPS hereby confirms that the physical condition as stated above was present during the handing over of the user in terms of section 40(1) of the Act.

Print initials and surname: .....

Signature: .....  
(member of SAPS who handed over custody)

Date: .....

Place: .....

[Copy to Review Board]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 23

## DEPARTMENT OF HEALTH

TRANSFER OF STATE PATIENTS FROM DETENTION CENTRE TO A DESIGNATED  
HEALTH ESTABLISHMENT

[Section 42(3) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ WResidential address: .....  
.....  
.....  
.....The above State patient, currently held in detention at .....  
(name of detention centre)must be transferred to .....  
(name of health establishment)

for care, treatment and rehabilitation services.

Signature: .....  
(head of national department)

Date: .....

Place: .....

[Copy to be forwarded to head of detention centre and the official *curator ad litem*]

[On receipt of a court order in terms of section 42(1) of the Act, Form J105, the national department must complete MHCA 23 and forward a copy to the detention centre and head of health establishment concerned]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 24

## DEPARTMENT OF HEALTH

TRANSFER OF STATE PATIENTS BETWEEN DESIGNATED HEALTH  
ESTABLISHMENTS

[Section 43(1) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

The above State patient shall be transferred:

From: ..... (name of health establishment)

To: ..... (name of health establishment)

Reasons for transfer:

.....  
.....  
.....  
.....

Print initials and surname: .....

Signature: .....

(head of provincial department)

Date: .....

Place: .....

Concurrence of head of province to where the State patient is to be transferred must be obtained where inter-provincial transfers are contemplated.

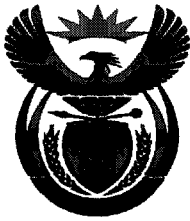
Signature: .....

(head of provincial department)

Date: .....

Place: .....

(Copy to be forwarded to official *curator ad litem*, head of national department and head of health establishment to where State patient is transferred)

DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 25

## DEPARTMENT OF HEALTH

NOTICE OF ABSCONDMENT TO SOUTH AFRICAN POLICE SERVICE (SAPS)  
AND REQUEST FOR ASSISTANCE TO LOCATE, APPREHEND  
AND RETURN USER

[Sections 40(4), 44(1) or 57(1) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Date of admission to health establishment: .....

The above user absconded from: .....

(name of health establishment)

Address: .....  
.....  
.....  
.....  
.....

Date of abscondment: .....

User is: (mark with a cross)

Assisted user ☐ Involuntary user ☐ State patient ☐ Mentally ill prisoner ☐

Diagnosis on medical condition:

.....  
.....  
.....  
.....  
.....

Estimation of likelihood of doing harm to self or others: (mark with a cross)

Little chance


Reasonable chance


Highly likely


Extremely likely


Circumstances of abscondment:

.....  
.....  
.....  
.....

Attach full report (if available)

Your assistance in locating and apprehending the above user is appreciated

Print initials and surname: .....

Signature: .....

(head of health establishment)

Date: .....

Place: .....

[In case of an assisted- or involuntary user: copy of this notice to be submitted to head of provincial department]

[In case of a State patient: copy of this notice to be submitted to Registrar or Clerk of the relevant Court official *curator ad litem* and head of national department]

[In case of a mentally ill prisoner: copy of this notice to be submitted to head of the prison from where the user was initially transferred and to head of national department]



MHCA 26

## DEPARTMENT OF HEALTH

NOTICE OF RETURN OF ABSCONDED USER TO THE HEALTH  
ESTABLISHMENT

(to be completed by the head of the health establishment)

[Sections 40(4), 44(1) or 57(1) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Date of admission to health establishment: .....

The above user absconded from: .....

(name of health establishment)

Address: .....  
.....  
.....  
.....  
.....

Date of abscondment: .....

Date of return: .....

Returned by (e.g. SAPS, self, relative): .....

State physical / mental condition:

.....  
.....  
.....  
.....  
.....  
.....

Print initials and surname: .....

(head of health establishment)

Signature: .....

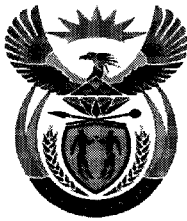
Date: .....

Place: .....

[In case of an assisted- or involuntary mental health care user: copy of this notice to be submitted to head of provincial department]

[In case of State patient: copy of this notice to be submitted to Registrar or Clerk of the relevant Court, official *curator ad litem* and head of national department]

[In case of a mentally ill prisoner: copy of this notice to be submitted to the head of the prison from where the user was initially transferred and to head of national department]



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 27

## DEPARTMENT OF HEALTH

LEAVE OF ABSENCE TO –  
STATE PATIENTS IN TERMS OF SECTION 45 OF THE ACT; OR  
ASSISTED- OR INVOLUNTARY MENTAL HEALTH CARE USERS IN TERMS  
OF SECTION 66(1)(j) OF THE ACT

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address or custodian's name and address whilst on leave of absence:

.....  
.....  
.....  
.....

The user is: (mark with a cross)

State patient ☐Assisted user ☐Involuntary user ☐

Date of commencement of leave: .....

Due date of return from leave: .....

Name of health establishment where the user's mental health status will be monitored and  
reviewed: .....

The user is to present him- / herself to this health establishment every ..... weeks /  
months to be monitored and his / her health status reviewed.



Name of health establishment(s) where care, treatment and rehabilitation will be provided and the nature of this: .....

Conditions of behaviour which must be adhered to by the user:

.....  
.....  
.....  
.....  
.....  
.....

Name of psychiatric hospital where the user is to be admitted if he / she relapses and / or is not complying with the terms and conditions applicable to the leave:

.....

Print initials and surname: .....

Signature: .....

(head of health establishment)

Date: .....

Place: .....

Print initials and surname: .....

Signature: .....

(custodian)

Date: .....

Place: .....



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 28

DEPARTMENT OF HEALTH

**CANCELLATION OF LEAVE OF ABSENCE –  
A STATE PATIENT IN TERMS OF SECTION 45 OF THE ACT; OR  
AN ASSISTED- OR INVOLUNTARY MENTAL HEALTH CARE USER IN TERMS  
OF SECTION 66(1)(j) OF THE ACT**

I hereby cancel the leave of absence of .....  
(name of State patient, assistant- or involuntary mental health care user)

File No. ....

You are not complying with the terms and conditions applicable to the leave of absence  
and/or have/has relapsed to the extent of requiring hospitalization.

Reasons for cancellation of leave of absence:

.....  
.....  
.....  
.....  
.....

You must return to .....  
(name of health establishment)  
by ..... (date) or you will be reported to the  
South African Police Services as absconded.

Print initials and surname: .....

Signature: .....

(head of health establishment)

Date: .....

Place: .....

(Copy to custodian)



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 29

## DEPARTMENT OF HEALTH

**APPLICATION FOR DISCHARGE OF STATE PATIENT TO JUDGE IN CHAMBERS  
(WHERE APPLICANT IS NOT AN OFFICIAL *CURATOR AD LITEM* OR  
ADMINISTRATOR)**

[Section 47(2)(e) of the Act]

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

.....

Charge against user: .....

**Person making application (mark with a cross)**

State patient him/herself ☐ Administrator ☐ Head of health establishment ☐  
(state what)

Responsible medical practitioner ☐ Spouse ☐ Associate ☐ Next of kin ☐ Other ☐

Reason for application:

.....  
.....  
.....  
.....

Has an application been made for discharge of the user within the preceding 12 months by  
any application other than an official *curator ad litem*?

Yes ☐

No ☐

If Yes provide details of the status of that application (and no need to proceed further with this form)

.....  
.....  
.....

Report from psychologist (if available)

Yes ☐

No ☐

In your opinion does the official *curator ad litem* have a conflict of interest with the user?

Yes ☐

No ☐

Give reasons:

.....  
.....  
.....

Supply proof that a copy of the application has been given to the official *curator ad litem* concerned.

Where the applicant is an "associate" state the nature of the substantial or material interest in the user

.....  
.....  
.....

Attach all reports you have available relevant to this application.

Provide details of any prior application for discharge that you are aware of:

.....  
.....  
.....

Print initials and surname: .....

Signature: .....

(Applicant)

Date: .....

Place: .....



MHCA 30

## DEPARTMENT OF HEALTH

APPLICATION FOR DISCHARGE OF STATE PATIENT TO JUDGE IN CHAMBERS  
(WHERE APPLICANT IS AN OFFICIAL *CURATOR AD LITEM* OR ADMINISTRATOR)  
[Section 47(2)(c) of the Act]

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Address: .....

Date of admission: .....

Charge against user: .....

Date declared a State patient: .....

Health establishment where user is being treated: .....

Application for discharge made by official *curator ad litem* / other

If other, state whom: .....

Has an application been made for discharge of the user within the preceding 12 months by any  
applicant other than an official *curator ad litem*?

Yes ☐No ☐

If yes, provide details of the status of that application (and no need to proceed further with this form)

.....  
.....  
.....  
.....

Report from psychologist (attach if available)

Yes ☐No ☐

Attach reports containing the history of the user's mental health status and a prognosis concerning  
their mental health status from:

- Head of the relevant health establishment
- Two mental health care practitioners at least one of whom should be a psychiatrist

Recommendations and comments on whether the application should be granted:

.....

.....

.....

.....

Print initials and surname: .....

Signature: .....

(official *curator ad litem*)

Date: .....

Place: .....

**Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act**

General information regarding:

- (a) escapes / attempted escapes
- (b) violent behaviour
- (c) seclusions and reasons for this
- (d) attempts at obtaining alcohol and dagga
- (e) any other unacceptable behaviour

Summarized history of user's mental health status:

.....

.....

.....

.....

Description of present mental condition:

.....

.....

.....

.....

**Prognosis:**

.....  
.....  
.....  
.....

**Recommendation(s):**

.....  
.....  
.....  
.....

Print initials and surname: .....

(head of health establishment)

Signature: .....

Date: .....

Place: .....

**Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act by a psychiatrist / medical practitioner**

Educational qualifications .....

Occupation before admission .....

Nature of charge .....

Review of medical and psychiatric history before admission:

.....  
.....  
.....

Present mental state and duration

.....  
.....  
.....

Diagnosis

.....

.....  
.....  
**Treatment received in hospital**  
.....  
.....  
.....

**Prognosis**  
.....  
.....  
.....

**Recommendations**  
.....  
.....  
.....

**Print initials and surname:** .....

**Signature:** .....

(psychiatrist / medical practitioner)

**Date:** .....

**Place:** .....

**Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act by a psychiatrist / medical practitioner**

**Educational qualifications** .....

**Occupation before admission** .....

**Nature of charge** .....

**Review of medical and psychiatric history before admission:**

.....  
.....  
.....  
**Present mental state and duration**  
.....  
.....



.....  
**Diagnosis**

.....  
.....  
.....

**Treatment received in hospital**

.....  
.....  
.....

**Prognosis**

.....  
.....  
.....

**Recommendations**

.....  
.....  
.....

**Print initials and surname:** .....

**Signature:** .....

(psychiatrist / medical practitioner)

**Date:** .....

**Place:** .....



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 31

## DEPARTMENT OF HEALTH

**ORDER BY JUDGE IN CHAMBERS FOR CONDITIONAL DISCHARGE OF STATE  
PATIENT  
[Section 47(6) of the Act]**

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address .....

.....

.....

.....

Nature of charge: .....

The above-mentioned State patient is hereby ordered to be conditionally discharged under the following terms and conditions:

.....

.....

.....

.....

Period of conditional discharge ..... (years)

Name and address of custodian into whose charge the user is transferred:

.....

.....

.....

.....

Where the user's mental health status will be monitored and reviewed:

.....

(name of health establishment)

The user is to present him / herself to this health establishment every ..... weeks / months to be monitored and his / her mental health status reviewed.

Name of the health establishment(s) where care, treatment and rehabilitation will be provided (if different from the preceding health establishment) and the nature of this: .....

.....

Conditions of behaviour which must be adhered to by the user:

.....

.....

.....

.....

Name of psychiatric hospital / care and rehabilitation center where the user is to be admitted if he / she relapses or if the conditions of the conditional discharge are violated.

.....

Print initials and surname: .....

Signature: .....

(Judge in chambers)

Date: .....

Place: .....

DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 32

## DEPARTMENT OF HEALTH

## SIX MONTHLY REPORT ON CONDITIONALLY DISCHARGED STATE PATIENT

[Section 48(3) of the Act]

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Address: .....

Nature of charge: .....

Date of conditional discharge: .....

Date of last report: .....

Comment on the extent to which the user is adhering to the terms and conditions of the discharge:

Current mental health status of user:

Recommendation to head of health establishment from where the user was conditionally discharged

Print initials and surname: .....

Signature: .....

(person monitoring the State patient)

Date: .....

Place: .....

(Copies to be forwarded to the State patient, head of relevant health establishment, clerk of the court and head of national department)



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 33

DEPARTMENT OF HEALTH

UNCONDITIONAL DISCHARGE BY HEAD OF HEALTH ESTABLISHMENT OF STATE  
PATIENT PREVIOUSLY DISCHARGED CONDITIONALLY

[Section 48(4)(a) of the Act]

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Address: .....

Date of conditional discharge: .....

Date of expiry of conditional discharge: .....

I hereby state that the period of the above user's conditional discharge has expired, that he / she has complied with the terms and conditions applicable to his / her mental health status and that his / her mental health status has not deteriorated.

The above user is hereby unconditionally discharged.

Print initials and surname: .....

Signature: .....  
(head of health establishment)

Date: .....

Place: .....

(Copies to be forwarded to the State patient, Registrar of the Court concerned, the official *curator ad litem* and national department)



MHCA 34

## DEPARTMENT OF HEALTH

**APPLICATION TO REGISTRAR OF THE HIGH COURT FOR AN ORDER  
AMENDING THE CONDITIONS / REVOKING THE CONDITIONAL DISCHARGE  
OF A STATE PATIENT  
[Section 48(5) of the Act]**

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Address: .....

.....

Nature of charge: .....

Residential address: .....

.....

.....

.....

**I hereby request that the conditional discharge of the above State patient be amended  
or revoked**

The above State patient has not complied with the following terms and conditions of his/her  
conditional discharge (explain)

.....

.....

.....

**and his/her mental health status has deteriorated (explain)**

.....

.....

.....

(if applicable) I recommend that the terms and conditions of the discharge be amended along the following lines:

.....

.....

.....

.....

Print initials and surname: .....

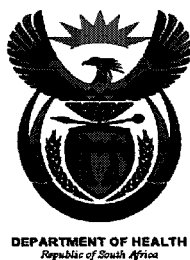
Signature: .....

(head of health establishment)

Date: .....

Place: .....

(Copies to be forwarded to the official *curator ad litem* and national department)



MHCA 35

## DEPARTMENT OF HEALTH

**APPLICATION BY STATE PATIENT TO JUDGE IN CHAMBERS FOR  
AMENDMENT TO ANY CONDITION APPLICABLE TO DISCHARGE OR  
REQUESTING UNCONDITIONAL DISCHARGE  
[Section 48(6) and (7) of the Act]**

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender:    Male ☐                  Female ☐

Residential address: .....

.....

.....

.....

Date of conditional discharge: .....

Date of last request for amendment / revocation of conditional discharge: .....

(may not be within six months of current application)

I hereby request that the following terms(s), condition(s) of my discharge be amended:

.....

.....

.....

.....

Reasons for amending condition / requesting unconditional discharge:

.....

.....



.....  
.....  
.....

Print initials and surname: .....

Signature: .....

(State patient)

Date: .....

Place: .....

---

**Decision by Judge in Chambers:**

.....  
.....  
.....  
.....  
.....  
.....

Print initials and surname: .....

Signature: .....

(Judge in Chambers)

Date: .....

Place: .....

(Copy to State patient, head of health establishment, head of the national department,  
Registrar of the High Court and *curator ad litem*)

MHCA 36



DEPARTMENT OF HEALTH  
Republic of South Africa

## DEPARTMENT OF HEALTH

**ASSESSMENT OF MENTAL HEALTH STATUS OF PRISONER FOLLOWING REQUEST  
FROM HEAD OF A PRISON AND/OR MAGISTRATE**

**[Sections 50(2) or 52 of the Act]**

Surname of user .....

First name(s) of user .....

File No. (if known) .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....  
.....  
.....  
.....

Nature of charge: .....

Prison number: .....

Date of examination: ..... Place of examination: .....

Category of designated mental health care practitioner: .....

Physical health status (filled in only by practitioner qualified to conduct physical examination)

(a) General physical health

.....  
.....  
.....

(b) Are there signs of injuries? Yes ☐ No ☐

(c) Are there signs of communicable disease? Yes ☐ No ☐

If the answer to (b) or (c) if Yes, give further particulars:

.....  
.....  
.....

Report facts on previous observations of mental illness (state who provided this information)

.....  
.....  
.....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places) .....

.....  
.....  
.....

Mental health status of the user at the time of the present examination:

.....  
.....  
.....

Type of illness (provisional):

.....  
.....  
.....

In my opinion the above-mentioned user:

Has homicidal tendencies

Yes ☐

No ☐

Has suicidal tendencies

Yes ☐

No ☐

Is dangerous

Yes ☐

No ☐

**Recommendation to head of prison**

The prisoner is mentally ill and requires care, treatment and rehabilitation

Yes ☐

No ☐

.....  
In my opinion the prisoner can be given care, treatment and rehabilitation within the prison and/or in a prison hospital

Yes ☐

No ☐

.....  
In my opinion the mental illness is of such a nature that the prisoner should be sent to a psychiatric hospital for care, treatment and rehabilitation:

.....  
.....

**Plan for care, treatment and rehabilitation for prisoner:**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

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.....

.....

.....

.....

.....

**Print initials and surname:** .....

**Signature:** .....

(mental health care practitioner who assessed mental health status of prisoner)

**Date:** .....

**Place:** .....



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 37

## DEPARTMENT OF HEALTH

**MAGISTERIAL ORDER TO HEAD OF PRISON TO –**  
**(a) TRANSFER PRISONER TO HEALTH ESTABLISHMENT; OR**  
**(b) TAKE NECESSARY STEPS TO ENSURE THAT THE REQUIRED LEVELS OF**  
**CARE AND TREATMENT ARE PROVIDED TO THE PRISONER CONCERNED**  
**[Sections 52(3)(a) or (b) of the Act]**

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

Prison number: .....

Charge against prisoner: .....

I hereby order that due to mental illness / intellectual disability the above user be transferred to a designated health establishment for care, treatment and rehabilitation in accordance with the procedure in section 54 of the Act.

Note: attach copy of MHCA 36 as completed by person who assessed the mental health care status of  
\_\_\_\_\_ the prisoner concerned.

OR**[Deleted subheading]**

I hereby order that the above user be provided with the required levels of care within the prison / prison hospital \*

Print initials and surname: .....

Signature: .....

(magistrate)

Date: .....

Place: .....

\* Delete which order by magistrate is not applicable

[Copy to be forwarded to the Administrator (if appointed) and the head of the national department]

MHCA 38

DEPARTMENT OF HEALTH  
Republic of South Africa

## DEPARTMENT OF HEALTH

APPLICATION TO MAGISTRATE FOR CONTINUED DETENTION OF A MENTALLY ILL  
PRISONER

[Sections 58(3) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Health establishment concerned: .....

File No: .....

Prison number: .....

Charge against person: .....

The above user has been admitted at: .....

(name of health establishment)

as a mentally ill prisoner since: ..... (date of admission)

The date of expiry of his / her prison sentence is: .....

(date of expiry of sentence)

Application for further confinement of the user in terms of Chapter V of this Act was made on .....

..... by .....

In terms of section 58(3) of the Act, I hereby request permission to keep this user at this health establishment and provide care, treatment and rehabilitation pending the outcome of the application.

Print initials and surname: .....

Signature: .....

(head of health establishment)

Date: .....

Place: .....



DEPARTMENT OF HEALTH  
Republic of South Africa

MHCA 39

DEPARTMENT OF HEALTH

APPLICATION TO MASTER OF A HIGH COURT TO APPOINT ADMINISTRATOR

[Section 60(1) and (2) of the Act]

Surname of user in respect of whom application is made .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Name of applicant: .....

(print initials and surname)

The above user has been admitted at: .....

(name of health establishment)

Relationship of applicant to the user:

.....

**If the applicant is not the spouse or next of kin:**

Give reasons why the spouse or next of kin are not making the application:

.....  
.....  
.....

**If the spouse or next of kin are not available:**

What steps have been made to trace the whereabouts of the spouse or next of kin?

.....  
.....  
.....

All medical certificates or relevant reports related to mental health status and the ability of the user to manage his / her own property (enclose and list)

.....  
.....  
.....

On what grounds do you believe that the user is incapable of managing his / her property?

.....  
.....  
.....

Have you seen the user within seven days of this application?

Yes

☐

No

☐

Give details:

.....  
.....  
.....

Give the particulars and estimated value of the property of the user:

.....  
.....  
.....

What is the annual income of the user?

.....

Who, in your opinion, would be most suited to be an administrator for the property of the user?

.....

Provide further particulars of the person (e.g. relationship with user, occupation)

.....  
.....  
.....

Give the name(s) and contact details of people who may be able to provide further information relating to the mental health status of the user:

.....  
.....  
.....

Attach proof that a copy of this application has been given to or served on the person in respect of whom this application is made:

.....

Name and surname of applicant: .....

Signature: .....

(applicant)

Date: .....

Place: .....



**Affidavit to be signed by a Justice of the Peace / Commissioner of Oaths**

I, the undersigned and applicant, hereby affirm that:

I am 18 years of age or older: .....

I am a relative, being .....

I am not a relative, being .....

Signature: .....

The above statements was solemnly declared or sworn before me at: .....

The respondent has acknowledged that he / she knows and understands the content of the affidavit which was sworn to / affirmed before me

Print initials and surname: .....

Signature: .....

(Justice of the Peace / Commissioner of Oaths)

Date: .....

Place: .....

---

**Decision of Master of the High Court in terms of section 60(13) of the Act**

Having considered the allegations and facts related to this application, I hereby –

(a) appoint .....

(name of person)

as an interim administrator pending the outcome of an investigation to be conducted;

(b) appoint .....

(name of person)

as the administrator of the above user's property;

- (c) order that an investigation be conducted in terms of section 60(4) of the Act;
- (d) assert that no administrator should be appointed.

Print initials and surname: .....

Signature: .....

(Master of the High Court)

Date: .....

Place: .....



MHCA 40

## DEPARTMENT OF HEALTH

DECISION BY MASTER OF THE HIGH COURT ON APPOINTMENT OF AN  
ADMINISTRATOR  
[Section 60(8) of the Act]

Following an investigation as set out in section 60(5) of the Act, I hereby order that:

- (a) .....  
(name of person)  
be appointed as the administrator of the property of: .....  
..... (user's name)
- (b) no administrator be appointed with respect to the property of: .....  
..... (user's name)
- (c) refer the matter for the consideration of a High Court Judge in Chambers.

Reason for this decision: .....  
.....  
.....  
.....

The powers, functions and duties of the administrator, if appointed, will be carried out in accordance with section 63 of the Act.

Print initials and surname: .....

Signature: .....

(Master of High Court)

Date: .....

Place: .....

(Copy to be forwarded to the applicant, person in respect of whom the application was made and to the head of the health establishment where the person concerned has been admitted)



MHCA 41

## DEPARTMENT OF HEALTH

**NOTICE OF APPEAL TO HIGH COURT JUDGE IN CHAMBERS REGARDING  
THE DECISION OF THE MASTER OF THE HIGH COURT TO APPOINT OR NOT  
TO APPOINT AN ADMINISTRATOR  
[Sections 60(10) of the Act]**

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

.....

Surname of applicant: .....

First name(s) of applicant: .....

Residential address: .....

.....

.....

.....

Relationship between applicant and mental health care user: (mark with a cross)

Spouse ☐ Next of kin ☐ Other (state what) ☐

Grounds of the appeal:

.....

.....

.....

.....

Facts on which the appeal is based:

.....  
.....  
.....  
.....

Print initials and surname: .....

Signature: .....

(Applicant)

Date: .....

Place: .....

MHCA 42

DEPARTMENT OF HEALTH  
Republic of South Africa

## DEPARTMENT OF HEALTH

NOTICE OF DECISION OF HIGH COURT TO APPOINT AN ADMINISTRATOR OR TO  
TERMINATE THE APPOINTMENT OF AN ADMINISTRATOR

[Sections 61(3) and 64(3) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

**Appointment of administrator**

Having considered all the relevant facts relating to the appointment of an administrator for the property of the above user in terms of section 61(3) of the Act, I hereby order that:

an administrator be appointed / no administrator be appointed (delete which is not applicable)

Reasons for decision:

.....  
 .....

**Continuance / termination of administratorship:**

Having considered all the relevant facts relating to the termination of the administratorship of the property of the above user in terms of section 64(3) of the Act, I hereby order that:

The powers, functions and duties of the administrator of the above user's property shall henceforth be terminated / shall continue (delete which is not applicable)

Print initials and surname: .....

Signature: .....

(Judge in the High Court)

Date: .....

Place: .....

[Copy to appellant, applicant, head of relevant health establishment, head of provincial department and, in the case of a decision regarding termination of administratorship, the administrator]



MHCA 43

## DEPARTMENT OF HEALTH

## CONFIRMATION OF APPOINTMENT OF ADMINISTRATOR

[Section 62 of the Act]

I hereby appoint:

.....

(name of administrator)

to be the administrator of the property of .....

(name of user)

Address of administrator: .....

.....

.....

.....

With effect from: .....(date)

As the administrator you will take care of, and administer the property of the above person and perform all acts incidental thereto and subject to any other law you will carry on the business or other undertakings of the person concerned.

You will continue to act as the administrator until your duties have been legally terminated.

Print initials and surname: .....

Signature: .....

(Master of the High Court)

Date: .....

Place: .....



MHCA 44

## DEPARTMENT OF HEALTH

APPLICATION FOR TERMINATION OF TERM OF OFFICE OF AN  
ADMINISTRATOR AND THE DECISION OF THE MASTER OF THE HIGH  
COURT

[Section 64 of the Act]

Name of administrator: .....

Application made by: ..... (initials and surname)

- (a) person in respect of whom an administrator was appointed;
- (b) the administrator;
- (c) person who made the application for the appointment of an administrator.

Grounds on which the application is made:

.....

.....

.....

.....

.....

.....

N.B. All medical certificates or relevant reports subsequent to appointment of an administrator are to be enclosed.

Estimated property value: .....

Signature: .....

(applicant)

Date: .....

Place: .....



**Decision of Master of High Court**

Having considered the facts relevant to this application I hereby:

- (a) terminate the appointment of the administrator;
- (b) decline to terminate the appointment of the administrator;
- (c) refer the matter for the consideration of a High Court Judge in chambers.

Reasons for decision:

.....

.....

.....

.....

.....

.....

.....

.....

Print initials and surname: .....

Signature: .....

(Master of the High Court)

Date: .....

Place: .....

[Copy to applicant and head of health establishment]



MHCA 45

## DEPARTMENT OF HEALTH

**NOTICE OF APPEAL TO HIGH COURT JUDGE IN CHAMBERS REGARDING  
THE APPLICATION FOR THE TERMINATION OF THE TERM OF OFFICE OF  
AN ADMINISTRATOR  
[Section 64(5) of the Act]**

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Name of applicant: .....

Appeal made by: .....

(print initials and surname)

who is a (delete where not applicable)

- (a) person in respect of whom an administrator was appointed;
- (b) the administrator;
- (c) person who made the application for the appointment of an administrator.

Grounds for appeal:

.....

.....

.....

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.....

Facts on which the appeal is based:

.....

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.....

Signature: .....

(Appellant)

Date: .....

Place: .....

[Copies to Master of High Court]



MHCA 46

## DEPARTMENT OF HEALTH

**NOTICE OF DECISION OF HIGH COURT JUDGE IN CHAMBERS REGARDING  
APPEAL AGAINST DECISION OF MASTER OF HIGH COURT  
[Sections 60(12) and 64(7) of the Act]**

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐Occupation: ..... Marital status: ☐ S ☐ M ☐ D ☐ W

Residential address: .....

.....

.....

.....

**Appointment of administrator**

Having considered all the relevant facts relating to the appointment of an administrator of the property of the above user in terms of section 61(12) of the Act, I hereby order that –

An administrator be appointed / no administrator be appointed (delete which is not applicable)

Reasons for this decision:

.....

.....

.....

.....

.....

.....

.....

.....

**Termination of term of office of administrator**

Having considered all the relevant facts relating to the termination of the administrator of the property of the above user in terms of section 64(7) of the Act, I hereby order that –

The powers, functions and duties of the administrator of the above user's property shall henceforth be terminated / shall continue (delete which is not applicable)

Reasons for this decision:

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

Print initials and surname: .....

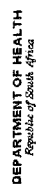
Signature: .....

(Judge of the High Court)

Date: .....

Place: .....

[Copy to appellant, applicant, head of relevant health establishment, head of provincial department and, in the case of a decision regarding termination of administratorship, the administrator]

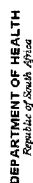


DEPARTMENT OF HEALTH

## REGISTER

**[Regulation 33 of the Regulations]**

[illegible]



MHCA 48

**DEPARTMENT OF HEALTH  
REGISTER  
[Regulations 36 and 37 of the Regulations]**

[illegible]