

DEPARTMENT OF HEALTH

NO. 7751

31 July 2026

CORRECTION NOTICE

MENTAL HEALTH CARE ACT, 2002

MENTAL HEALTH CARE ACT, 2002 (ACT NO. 17 OF 2002) GENERAL REGULATIONS

The Mental Health Care Act, 2002-General Regulations published under Notice No. 1467 published in Government Gazette No. 27117 of 15 December 2004 as amended by Amendment made in terms of the Mental Health Care Act, 2002 (Act No. 17 of 2002) published in Government Gazette No. 40515, Government Notice No. 1590 published on 23 December 2016 is hereby corrected as follows:

All Forms published in both sets of Regulations are hereby repealed and substituted by the Forms in the Schedule.

DR PAKISHE AARON MOTSOLEDI, MP
MINISTER OF HEALTH

DATE:

FORM MHCA 01

DEPARTMENT OF HEALTH

**REPORT TO MENTAL HEALTH REVIEW BOARD ON PROVISION OF CARE,
TREATMENT AND REHABILITATION WITHOUT CONSENT OR
EMERGENCY ADMISSION
[Section 9(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:

.....

.....

.....

.....

Date of admission:

Time of admission:

Name of health establishment:

Reason for admission without consent:

Based on my/practitioners at this health establishment's assessment, any delay in providing care, treatment and rehabilitation services / admission may, due to mental illness, result in:

- (a) the death or irreversible harm to the User
Reasons for this assessment (including mental health status and behavioural reasons)
.....
.....

- (b) the User inflicting serious harm to him/herself or others
Reasons for this assessment (including mental health status and

FORM MHCA 01

behavioural reasons)

- (c) the User causing serious damage to or loss of property belonging to him/herself or to others
 Reasons for this assessment (including mental health status and behavioural reasons)

I (name of mental health care practitioner)
 hereby declare that I have personally assessed
 (name of mental health care user) at
 (name of health establishment) on(date).

Designation:

Contact Numbers:

.....
 Signature:

Outcome of assessment within 24 hours-

- (a) An application for involuntary or assisted care, treatment and rehabilitation was made:-

Date of application: Time of application:

- (b) The User agreed to voluntary care, treatment and rehabilitation.
 (c) Patient discharged as a mental health care user.

Print initials and surname.....

.....
 Signature:

(Health care provider ☐ or Head of health establishment ☐)

Date:

(Submit to relevant Review Board)

FORM MHCA 02**DEPARTMENT OF HEALTH****REPORT ON EXPLOITATION, PHYSICAL OR OTHER ABUSE, NEGLECT OR
DEGRADING TREATMENT OF A MENTAL HEALTH CARE USER****[Section 11(2) of the Act]**

(All the information contained in this Form will be held strictly confidential).

I.....
(name/s).....
(address)☐ hereby declare that I have witnessed exploitation, physical or other abuse,
neglect or degrading treatment of the following mental health care user:☐ hereby declare that I have been through exploitation, physical or other abuse,
neglect or degrading treatment**A. Details of User (where known)**

First Name and Surname of User.....

Date of birth or estimated age

Gender: Male ☐ Female ☐Occupation Marital status: S ☐ M ☐ D ☐ W ☐Residential address:
.....
.....
.....
.....**B. Name of health establishment or other place where the alleged incident occurred**
.....Address:
.....
.....
.....**C. Date of incident****D. Brief description of the User:**
.....

E. Description of the alleged incident:

This image shows a full page of primary-ruled paper. It features multiple horizontal rows, each consisting of two parallel dashed lines with a small gap between them, creating a series of uniform writing spaces across the entire page.

Print initials and surname

Contact number:

Signature under oath:

(person who witnessed alleged incident)

Date:

I certify that:

- i. The deponent acknowledged to me that:
 - a. He/she knows and understands the contents of this declaration;
 - b. He/she has no objection to taking the prescribed oath;
 - c. He/she considers the prescribed oath to be binding on his/her conscience;
- ii. The deponent signed this declaration in my presence at on this day of 20.....

Signature: Commissioner of Oath: Ex-Officio

Name:

Rank / Designation:

(Original to be submitted to the relevant Mental Health Review Board)

FORM MHCA 03**DEPARTMENT OF HEALTH****DISCHARGE REPORT FROM THE MENTAL HEALTH ESTABLISHMENT**
[Section 16, 37(6) or 56 of the Act]

Full name of User.....

ID Number:

Date of birth or estimated age

Gender: Male ☐ Female ☐

Name of health establishment:

Date of admission:

Date of discharge:

Diagnosis on discharge:

Planned further care, treatment and rehabilitation:

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

Compiled by:

Print initials and surname:

Designation:

Signature:

(Head of health establishment)

Print initials and surname:

Signature:

Date:

Copy to be submitted to the relevant authority in terms of the applicable provision:

Review Board ☐Registrar High Court ☐Magistrate ☐Head of Prison ☐Head of National Department ☐Curator ☐

FORM MHCA 04**DEPARTMENT OF HEALTH****APPLICATION TO THE HEAD OF HEALTH ESTABLISHMENT CONCERNED
FOR ASSISTED OR INVOLUNTARY CARE, TREATMENT AND
REHABILITATION****[Section 27(1) and 27(2) or 33(1) and 33(2) of the Act]**

(A staff member assisting the Applicant in completing this form must record his/her name, surname and designation)

Name, surname and designation of staff member-.....

A. INFORMATION REGARDING THE USER

I hereby apply for—.

assisted care ☐ or involuntary care ☐:

Surname of User:

First name(s) of User:

Date of birth: or estimated age:

Gender: Male ☐ Female ☐

Marital status: S ☐ M ☐ D ☐ W ☐

Employment: Yes ☐ or No ☐

Property: Yes ☐ or No ☐

Income source: Pension ☐

Grant ☐

Other ☐ (Specify).....

None ☐

Is there a reason to believe that an administrator or curator needs to be appointed to manage the financial affairs of the User Yes ☐ No ☐

Residential address and contact details:

.....

.....

Surname of applicant:
 First name(s) of applicant:
 Date of birth of applicant: (must be over 18 years of age)
 Residential address and contact details:

or

FORM MHCA 04

(iii) Unknown/Untraceable (state efforts made to trace)

.....

.....

.....

E. Reasons for the Application:

I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons (e.g, what did he/she do or say?):

.....

.....

.....

.....

F. In the case of an application for involuntary care:

In your opinion:

(i) Is the User a danger to self and others due to his/her mental illness?

Yes ☐ No ☐

(ii) Is the User willing to receive care, treatment and rehabilitation if needed?

Yes ☐ No ☐

(iii) Is the User able to make an informed decision?

Yes ☐ No ☐

I also attach the following information in support of my application (if available)

Medical certificates: ☐

History of past mental illness: ☐ / intellectual disability: ☐

Other: ☐

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FORM MHCA 04

I wish to have representation/Legal Representation/Legal Aid

for myself

Yes ☐ No ☐

or on behalf of the User

Yes ☐ No ☐

Print initials and surname (Applicant).....

Signature (Applicant):

Date:

Place:

Note: Applicant must sign under oath

F. OATH/AFFIRMATION

I certify that:

- iii. The deponent acknowledged to me that:
 - a. He/she knows and understands the contents of this declaration;
 - b. He/she has no objection to taking the prescribed oath;
 - c. He/she considers the prescribed oath to be binding on his/her conscience;
- iv. The deponent signed this declaration in my presence at on this day of 20.....

Signature: Commissioner of Oath: Ex-Officio

Name:

Rank / Designation:

(Submit original to Review Board)

FORM MHCA 05

DEPARTMENT OF HEALTH

**REPORT ON COMPLETION OF EXAMINATION AND FINDINGS BY
MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION
FOR ASSISTED OR INVOLUNTARY CARE TREATMENT AND
REHABILITATION**

[Section 27(5) or 33(5) of the Act]

Section 1

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:

.....

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.....

.....

Section 2

Date of examination: Place of examination:

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

(a) General physical health:

.....

.....

.....

.....

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

If yes, please indicated whether you believe this is as a result of abuse?

Yes ☐ No ☐ Unsure ☐If yes, was this abuse reported/investigated? Yes ☐ No ☐(c) Are there signs of communicable diseases? Yes ☐ No ☐

FORM MHCA 05

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

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

Section 3

Information on User received from other person(s) or family (state names and contact details):

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Section 4

Previous mental health history if known (State dates and places):

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Section 5

Mental health status of the User at the time of the present examination (describe symptoms or diagnostic criteria):

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Section 6

Type of illness (provisional diagnosis):

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

FORM MHCA 05**Section 7**

In my opinion the above-mentioned User—

has homicidal tendencies due to mental illness Yes ☐ No ☐

has suicidal tendencies due to mental illness Yes ☐ No ☐

is a risk to inflicting serious harm to him/herself or others or causing serious damage to property belong to him/her or other due to mental illness Yes ☐ No ☐

Section 8

Recommendation to head of health establishment on an application for assisted care, treatment and rehabilitation services only (**Skip this section if section 9 of this form is applicable**) —

An application was made for assisted care, treatment and rehabilitation services ☐ or involuntary care ☐, treatment and rehabilitation services ☐

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services for their own health and safety or the health and safety of others? Yes ☐ No ☐

2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes ☐ No ☐

3. Is the User willing to receive care, treatment and rehabilitation services? Yes ☐
No ☐

Section 9

Recommendation to head of health establishment on an application for Involuntary care, treatment and rehabilitation services only (**Skip this section if you have completed section 8**)

1. Is the User suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services? Yes ☐ No ☐

FORM MHCA 05

2. Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes ☐ No ☐

3. Does the User refuse to receive care, treatment and rehabilitation services? Yes ☐ No ☐

4. Is the User in your view, likely to inflict serious harm on him/herself or others? Yes ☐ No ☐

5. Is care, treatment and rehabilitation services, in your view necessary for the protection of the User's financial interests or reputation? Yes ☐ No ☐

Section 10

Based on the abovementioned information my recommendation to the head of health establishment is that the User should—

1. Receive voluntary care, treatment and rehabilitation services ☐

2. Receive assisted in-patient care, treatment and rehabilitation services ☐

3. Undergo 72-hour assessment following the application for involuntary care, treatment and rehabilitation services to determine the need for further care, treatment and rehabilitation services ☐

Section 11

I declare that I have personally informed the mental health care User of his/her rights, including his/her right to representation including the right to legal representation and/or Legal Aid, and the right to have his/her financial interests or reputation safeguarded and his/her right to have an administrator or curator appointed.

Comment:

.....
.....

FORM MHCA 05

I (name of mental health care practitioner)
hereby declare that I have personally assessed
..... (name of mental health care user) at
..... (name of health establishment) on (date).
.....

Signature:

Category of designated mental health care practitioner:

Registration number with relevant Council:

Date:

Place:

FORM MHCA 06

DEPARTMENT OF HEALTH

**72-HOUR ASSESSMENT AND FINDINGS OF MEDICAL PRACTITIONER AND
ANOTHER MENTAL HEALTH CARE PRACTITIONER AFTER HEAD OF
HEALTH ESTABLISHMENT HAS APPROVED INVOLUNTARY CARE,
TREATMENT AND REHABILITATION SERVICES
[Section 34(1) of the Act]**

Section 1

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:

.....

.....

.....

.....

Section 2

Date and time of the beginning of 72-hour assessment:

Place of assessment:

Section 3

(a) General physical health (To be completed by medical practitioners only):

.....

.....

.....

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

If yes, please indicate whether you believe this is as a result of abuse?

Yes ☐ No ☐If yes, was this abuse reported/investigated? Yes ☐ No ☐ Not known ☐

FORM MHCA 06

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

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

.....

.....

.....

.....

.....

Section 4

Past mental health history of the User (State dates and places):

.....

.....

.....

Section 5

Mental health status of the User during the 72 hours assessment period:

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.....

.....

Section 6

Type of illness (provisional diagnosis):

.....

.....

.....

In my opinion the above-mentioned User:-

has homicidal tendencies due to mental illness Yes ☐ No ☐

has suicidal tendencies due to mental illness Yes ☐ No ☐

is at risk due to mental illness Yes ☐ No ☐

Section 7

Recommendation to head of health establishment - application for involuntary care:

Is the User capable of making an informed decision on the need to receive care, treatment and rehabilitation services? Yes ☐ No ☐

Does the User refuse to receive care, treatment and rehabilitation services? Yes ☐ No ☐

Is the User in your view, likely to inflict serious harm on him /herself or others?

Yes ☐ No ☐

Section 8

1. Receive voluntary care, treatment and rehabilitation service ☐

2. Receive assisted care, treatment and rehabilitation services ☐

3. Continue to receive involuntary in-patient care, treatment and rehabilitation services ☐

4. Receive involuntary out-patient care, treatment and rehabilitation services ☐

5. Be discharged from the Mental Health Care Act ☐

I declare that I have personally informed the mental health care User of his/her rights, including his/her right to representation including the right to legal representation and/or Legal Aid, and the right to have his/her financial interests and/or reputation safeguarded.

Comment:.....

FORM MHCA 06**Section 10**

Print initials and surname:

Registration Category:

Signature:

Date:

Category of designated mental health care practitioner for example 'nurse', psychologist' or
'medical practitioner':

Date:

Place:

FORM MHCA 07

DEPARTMENT OF HEALTH

**NOTICE BY HEAD OF HEALTH ESTABLISHMENT ON HIS/HER DECISION
WHETHER TO PROVIDE ASSISTED- OR INVOLUNTARY INPATIENT CARE,
TREATMENT AND REHABILITATION SERVICES**
[Sections 27(9), 28(1), 33(7) and 33(8) of the Act]

Section 1

I(name of head of health establishment)
hereby:

Approve the application ☐

Do not approve the application ☐

to the assisted care, treatment and rehabilitation ☐

to the in-patient involuntary care, treatment and rehabilitation ☐
of(name of User).

Section 2

Whereas the findings of the registered medical practitioner and another mental health care practitioner concur that the User:-

(a) should ☐ should not ☐ receive assisted care, treatment and rehabilitation services; or

(b) must ☐ must not ☐ receive involuntary care, treatment and rehabilitation services

I am satisfied ☐ not satisfied ☐ that the restrictions and instructions on the mental health care User's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

The reasons for consenting are as follows:

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

Print initials and surname:

Signature:(head of health establishment)

Date: Time:

Place:

(Copy to Applicant and original to the Review Board)

FORM MHCA 08**DEPARTMENT OF HEALTH**

**NOTICE BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD
REQUESTING APPROVAL FOR FURTHER INVOLUNTARY CARE,
TREATMENT AND REHABILITATION ON AN INPATIENT BASIS
[Section 34(3)(c) of the Act]**

Ihereby request the
.....
(name of head of health establishment)

approval from the Review Board for further involuntary care, treatment and rehabilitation
on an inpatient basis of:
(name of User)

The findings of the mental health care practitioner and medical practitioner are that the
User requires further involuntary care, treatment and rehabilitation.

I am satisfied that the restrictions and intrusions on the mental health care user's right to
movement, privacy and dignity are proportionate to the care, treatment and rehabilitative
services contemplated.

The basis of this request for further involuntary care, treatment and rehabilitation on an
inpatient basis is that:

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

Attached hereto please find the copies of the following:-

- (a) the application to obtain involuntary care, treatment and rehabilitation [MHCA 04];
- (b) the written findings given in terms of sections 27(5) and 33(5) [MHCA 05]
- (c) the notice given in terms of section 33(8) [MHCA 07]; and
- (d) the assessment findings [MHCA 06].

Signature:
(Head of health establishment)

Date:

Place:

(Original to Review Board & Copy (excluding attachments) to applicant)

FORM MHCA 09

DEPARTMENT OF HEALTH

**NOTICE BY HEAD OF HEALTH ESTABLISHMENT AFTER 72-HOUR
ASSESSMENT PERIOD INFORMING REVIEW BOARD THAT MENTAL
HEALTH CARE USER WARRANTS FURTHER INVOLUNTARY CARE,
TREATMENT AND REHABILITATION ON AN OUTPATIENT BASIS**
[Section 34(3)(b) of the Act]

I hereby inform
(name of head of health establishment)

the Review Board that
(name of mental health care user)

requires further involuntary care, treatment and rehabilitation on an outpatient basis.

I am satisfied that the restrictions and intrusions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

The basis of this request for further involuntary care, treatment and rehabilitation on an outpatient basis is that:-

- (a) The User is suffering from a mental illness or severe/profound mental disability and requires care, treatment and rehabilitation services for his/her health or safety or the health or safety of other people or for the protection of the financial interests or reputation of the User;
- (b) The User is currently incapable of making an informed decision on the need for the care, treatment and rehabilitation services
- (c) The User is refusing care, treatment and rehabilitation services

Signature:
(Head of health establishment)

Date:

Place:

[Copy to mental health care user and original to Review Board]

FORM MHCA 10

DEPARTMENT OF HEALTH

**TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER -
SCHEDULE OF CONDITIONS RELATING TO HIS OR HER INVOLUNTARY
OUTPATIENT CARE, TREATMENT AND REHABILITATION SERVICES
[Section 34(3)(b) or (5) 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:

.....

.....

.....

.....

Name of custodian into whose charge the User is discharged:

Address of custodian:

- i. The User's mental health status will be monitored and reviewed at (name of health establishment)
- ii. The User is to present him / herself to this health establishment everyweeks / months to have his or her mental health status reviewed.
- iii. Name of health establishment(s) where involuntary mental health care, treatment and rehabilitation will be provided on an outpatient basis if different from preceding health establishment:
- iv. Conditions of behaviour which must be adhered to by the User:
.....
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.....
.....
.....

Name of psychiatric hospital and/or care and rehabilitation centre where the User is to be admitted if he / she relapses to the extent of being a danger to him / herself or others if he / she remains an involuntary outpatient, or to which he / she is to be admitted if the conditions of outpatient care are violated
(name of health establishment)

FORM MHCA 10

Print initials and surname:

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

Date:

Place:

.....
Signature of User (understands and accepts the stipulated conditions).....
Signature of custodian (understands and accepts the stipulated conditions)**(Original to Review Board and copy to User, custodian and head of health establishment to whom User was referred on outpatient basis)**

FORM MHCA 11

DEPARTMENT OF HEALTH

**TRANSFER OF ASSISTED / INVOLUNTARY MENTAL HEALTH CARE USER
ON INPATIENT BASIS TO ANOTHER HEALTH ESTABLISHMENT**
[Section 27(10) and 34(4), of the Act]

.....
(name and surname of mental health care user)

an assisted ☐ or

Involuntary mental health care user ☐

on an inpatient basis who was admitted to
..... (name of health establishment)

on (date) must be

transferred to (name of health establishment)

Print initials and surname:
(head of health establishment)

Signature:
(Head of health establishment)

Date:

Place:

(Copy to Review Board)

FORM MHCA 12

DEPARTMENT OF HEALTH

**DISCHARGE OF INVOLUNTARY MENTAL HEALTH CARE USER FROM
INPATIENT TO OUTPATIENT CARE OR CANCELLATION OF THE
DISCHARGE**

[Section 34(3) and 34(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 ☐

Residential address:

A. Discharge from inpatient to outpatient care

This involuntary inpatient at
 (name of health establishment) has improved to such an extent that he/she should be
 provided with care, treatment and rehabilitation services as an outpatient as dated on the
 schedule of conditions attached to this transfer as outlined in the attached MHCA 10.

B. Cancellation of the discharge

This involuntary outpatient previously discharged with prescribed conditions on
and being monitored and reviewed at
has not
 complied with the terms and conditions applicable to his / her discharge / relapsed to the
 extent of being a danger to him / herself or others if he / she remains an involuntary
 outpatient, and must be admitted as an involuntary inpatient
 to.....(name of health
 establishment)

Specific reasons for transfer to inpatient care are:

Print initials and surname:

Signature:
 (Head of health establishment)

Date:

Place:

FORM MHCA 13A

DEPARTMENT OF HEALTH

**PERIODICAL REPORT ON MENTAL HEALTH CARE USER
(ASSISTED/INVOLUNTARY USER/MENTALLY ILL PRISONER)
[Sections 30(2), 37(2) and 55(1) of the Act]**

Section 1: Biographical information

Surname of User:

First name(s) of User:

Date of birth: or estimated age:

Gender Male ☐ Female ☐

The User is an: (mark with a cross)

Assisted User ☐ Involuntary User ☐ Mentally ill prisoner ☐

Name of health establishment concerned:

Registration number (if any):

Date of first admission of mental health care user under this section:

Section 2: Assessment

Mental health status: (Short statement of the mental health status before and since admission, since the last report, and the present condition, with special reference to any symptom indicating homicidal, suicidal or dangerous tendencies)

Before admission:

.....

Since admission / previous periodical report:

.....

Present mental status:

.....

FORM MHCA 13A

Physical condition of User:

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.....

Diagnosis:

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Section 3: Clinical management, treatment and rehabilitation plan

Present treatment programme to be followed, including psycho-pharmacological, ECT, occupational therapy or psychotherapy social work intervention with family, leave of absence to family, etc):

Medical:

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Psychological:

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.....

Social (including the safeguarding of the User's financial interests):

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Occupational:

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FORM MHCA 13A

Physiotherapy (if required):

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.....

Family contacts:

Personal ☐ Correspondence ☐ Regular ☐ Seldom ☐ Never ☐

In the case of never, what has been done to trace the family?

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.....

.....

Section 4: Recommendation in terms of Section 30 or 37 or 55(1)

(a) The User is suffering from a mental illness or severe/profound mental disability and requires care, treatment and rehabilitation services for his/her health or safety or the health or safety of other people or for the protection of the financial interests or reputation of the User;

(b) The User is currently incapable of making an informed decision on the need for the care, treatment and rehabilitation services

and

(c) The User is refusing ☐ / not refusing ☐ care, treatment and rehabilitation services

Should the User status remain unchanged? Yes ☐ No ☐

Briefly motivate:

.....

.....

If the User is an involuntary inpatient, should he / she be transferred to involuntary outpatient care?

Yes ☐ No ☐

Briefly motivate:

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.....

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FORM MHCA 13A

Please add additional paper if required, as this is extremely important:

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Print initials and surname of assessing practitioner:

Signature:
(assessing practitioner)

Date:

Place:

Section 5: Instructions and remarks

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.....
.....

Signature:
(Head of health establishment)

Date:

Place:

(Original to Review Board and copy of report in case of mentally ill prisoner to relevant magistrate, administrator, if appointed, and head of relevant prison)

FORM MHCA 13B

DEPARTMENT OF HEALTH

PERIODICAL REPORT ON STATE PATIENT

[Section 46(2) of the Act]

Surname of State patient:

First name(s) of State patient:

Date of birth: or estimated age:

Gender: Male ☐ Female ☐

Name of health establishment concerned:

Registration number (if any):

Date of first admission of the state patient under this section:

Mental health status: (Short statement of the mental health status before and since admission, since the last report, and the present condition, with special reference to any symptom indicating homicidal, suicidal or dangerous tendencies)

Before admission:

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Since admission / previous report:

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Present mental status:

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Present treatment for example psycho-pharmacological treatment, ECT, occupational therapy or psychotherapy:

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FORM MHCA 13B

Present physical condition:

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Diagnosis at present date:

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.....

.....

Family contacts:Personal ☐ Correspondence ☐ Regular ☐ Seldom ☐ Never ☐

In the case of never, what has been done to trace the family?

.....

.....

.....

State patients (section 46 of the Act)

Charge faced:

.....

.....

Should the User be discharged conditionally?

Yes ☐ No ☐

Comment:

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.....

Should the User be discharged unconditionally?

Yes ☐ No ☐

Comment:

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.....

.....

Give reasons if the 'present mental status' reflects a normal picture and further confinement is recommended:

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.....

FORM MHCA 13B

Comment on the merit of granting the User leave of absence:

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.....

Recommendation on a plan for further care, treatment and rehabilitation (to be completed for any of assisted and involuntary Users and mentally ill prisoners)

(Specify treatment programme followed, give details of psychiatric interviews, counselling, group therapy sessions etc., stating clearly the aims of treatment, progress made, assessments done, changes made and patient's reactions to changes):

Please add additional paper as this is extremely important!!

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Print initials and surname of assessing practitioner:

Signature:

(assessing practitioner)

Date:

Place:

Instructions and remarks:

.....

.....

.....

Signature:

(head of health establishment)

Date:

Place:

FORM MHCA 13B**STATE PATIENTS**

[This part must be completed by head of national department (or designated official)]

Considerations and remarks:

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

Recommendations:

(a) Further care and treatment:

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.....
.....

b) Leave of absence (State patients):

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

(c) Discharge of User:

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

Signature:

(Head of National Department):

Date:

Place:

(Copy to be sent back to the Head of health establishment)

FORM 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 User is willing ☐ unwilling ☐ 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.

FORM MHCA 14

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

The Review Board has 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 has considered the appeal in the prescribed procedure and has decided that:-

- (a) the User should be discharged from the health establishment ☐
- (b) the User should receive care, treatment and rehabilitation services as a voluntary User ☐
- (c) the User should receive assisted care, treatment and rehabilitation services as an assisted inpatient ☐
- (d) the User should receive involuntary care, treatment and rehabilitation services as an inpatient ☐ outpatient ☐

Reasons for this decision:

.....

Print initials and surname:

Signature:

(Chairperson 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)

FORM 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 appellant? Yes ☐ No ☐

If No to the above:

Surname of appellant:

First name(s) of appellant:

Contact number of appellant:

Residential address:

.....

.....

.....

Relationship between appellant and mental health care user: (mark with a cross)Spouse ☐ Partner ☐ Associate ☐ Next of kin ☐ Parent ☐ Guardian ☐Other ☐(specify)

Grounds for the appeal:

.....

.....

.....

.....

.....

FORM MHCA 15

Facts on which the appeal is based:

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

I, the undersigned/wish to have representation/Legal Representation/Legal Aid

for myself or on behalf of Yes ☐ or No ☐

Signature:

(appellant)

Date:

Place:

FORM MHCA 16**DEPARTMENT OF HEALTH**

**ORDER BY THE HIGH COURT FOR FURTHER
HOSPITALISATION/IMMEDIATE DISCHARGE OF AN INVOLUNTARY
MENTAL HEALTH CARE USER
[Section 36(c) of the Act]**

In the High Court of South Africa. Division

In the matter of
(involuntary mental health care user's name)

at present being confined at.....
(name and health establishment)

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

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) financial affairs be managed and administered according to the provisions of Chapter VIII of the Act; or
- (b) be discharged immediately.
- (c) Other (specify)

By order of the Honourable Justice

Date:

Place:

Registrar:

(Copy to be sent applicant, appellant, Review Board and head of health establishment)

FORM MHCA 17

DEPARTMENT OF HEALTH

**DECISION/RECOMMENDATION BY REVIEW BOARD FOLLOWING
PERIODIC REVIEWS/ REPORTS ON ASSISTED OR INVOLUNTARY
MENTAL HEALTH CARE USERS OR MENTALLY ILL PRISONERS**
[Sections 30(4), 37(4) or 55(4) 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 has 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 (Specify) ☐

FORM MHCA 17

The Review Board has decided/recommended that:

- (a) The User should be discharged ☐
- (b) The User should receive care, treatment and rehabilitation services as a voluntary User ☐
- (c) The User should receive care, treatment and rehabilitation services as an assisted inpatient ☐
- (d) The User should receive involuntary care, treatment and rehabilitation services as an inpatient ☐ / outpatient ☐

Reasons for this decision/recommendation:

.....

Print initials and surname:

Signature:

(Chairperson of Review Board)

Date:

Place:

[Copies to be sent in the case of:

Assisted or involuntary User: to the mental health care user, applicant, head of health establishment concerned and head of provincial department;

Mental ill prisoners: mentally ill prisoner, administrator/curator (if appointed) head of health establishment concerned, relevant magistrate, head of relevant prison and head national department.]

Periodic Report No.....is due on

FORM MHCA 18**DEPARTMENT OF HEALTH****SUMMONS TO APPEAR BEFORE A REVIEW BOARD****[Section 11(2), 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 summonsed is to produce any book, record, document or any other item(s))
and you are hereby directed to produce:

.....

.....

.....

.....

(specify the book, record, document or any other item(s) concerned)

Given under the hand of the Chairperson of the Review Board, this day
of

Signature:

(Chairperson of Review Board)

FORM MHCA 19**DEPARTMENT OF HEALTH****REQUEST BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD TO
TRANSFER MENTAL HEALTH CARE USER/STATE/MENTALLY ILL
PRISONER**

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

Surname of mental health care user/state patient/mentally ill prisoner

First name(s) of mental health care user/state patient/mentally ill prisoner

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:

.....

FORM MHCA 19

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:

FORM MHCA 20**DEPARTMENT OF HEALTH****ORDER BY REVIEW BOARD TO TRANSFER MENTAL HEALTH CARE USER/STATEPATIENT/MENTALLY ILL PRISONER**

- (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 mental health care user/state patient/mentally ill prisoner:

First name(s) of mental health care user/state patient/mentally ill prisoner:

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)

has considered documentation and representation relevant to the transfer of the above User to a maximum-security facility.

The Review Board has considered inter alia whether-

- (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:

.....

.....

.....

.....

.....

.....

.....

FORM MHCA 20

The above mental health care user/state patient/mentally ill prisoner 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 and the Head of health establishment. With respect to state patients and mentally ill prisoners the order must be sent to the head of the national department)

FORM 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 state patient/mentally ill prisoner

First name(s) of state patient/mentally ill prisoner.....

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)

FORM MHCA 22

DEPARTMENT OF HEALTH

**HANDING OVER CUSTODY BY THE SOUTH AFRICAN POLICE SERVICES
(SAPS) OF A PERSON SUSPECTED OF BEING MENTALLY ILL AND LIKELY
TO INFLICT SERIOUS HARM TO HIM/HERSELF OR OTHERS
[Section 40(1) of the Act]**

A. 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 practitioner ☐

that

.....

.....

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

is suffering from a mental illness and is likely to inflict serious harm to him/herself or others.

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: Force No:
(Member of SAPS)

Date:

Time:

Place:

FORM MHCA 22

B. 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 mental status of the person will be assessed, and an application will be made in terms of section 33 if applicable

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]

C. The SAPS hereby confirms that the physical condition as stated above was present during the handing over 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)

FORM MHCA 23

DEPARTMENT OF HEALTH

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

[Sections 42(3) of the Act]

OR

TRANSFER OF MENTALLY ILL PRISONERS FROM PRISON TO
DESIGNATED HEALTH ESTABLISHMENT

[Section 53(2) of the Act]

Surname of state patient/mentally ill prisoner:

First name(s) of state patient/mentally ill prisoner:

Date of birth: or estimated age:

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

FORM MHCA 24

DEPARTMENT OF HEALTH

**TRANSFER OF STATE PATIENTS AND MENTALLY ILL PRISONERS
BETWEEN DESIGNATED HEALTH ESTABLISHMENTS
[Sections 43(1) and 54(1) of the Act]**

Surname of state patient/mentally ill prisoner:

First name(s) of state patient/mentally ill prisoner:

Date of birth: or estimated age:

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

The above state patient or mentally ill prisoner shall be transferred:

From: (name of health establishment)

To: (name of health establishment)

Reasons to transfer:

.....

.....

.....

.....

Print Initials and Surname:

Signature:

(Head of provincial department)

Date:

Place:

Concurrence of Head of Province to where the state patient or mentally ill prisoner 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 or mentally ill prisoner is transferred)

FORM 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 assisted user/involuntary user/state patient/mentally ill prisoner:
.....

First name(s) of assisted user/involuntary user/state patient/mentally ill prisoner:
.....

Date of birth: or estimated age:

Gender: Male ☐ Female ☐

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

Date of admission to health establishment:

The above assisted user/involuntary user/state patient/mentally ill prisoner absconded
from:(name of health establishment)

Address:

.....

.....

.....

.....

Date of abscondment:

Absconder 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 ☐ High likely ☐ Extremely likely ☐

FORM MHCA 25

Circumstances of abscondment:

.....

.....

.....

.....

Attach full report (if available)

Your assistance in locating and apprehending the above assisted/involuntary user/state patient/mentally ill prisoner 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 the 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)**

FORM MHCA 26

DEPARTMENT OF HEALTH

**NOTICE OF THE RETURN OF AN ABSCONDED ASSISTED
USER/INVOLUNTARY USER/STATE PATIENT/MENTALLY ILL PRISONER**
[Section 40(4), 44(1) or 57(1) of the Act]
[to be completed by the head of Health Establishment]

Surname of assisted user/ involuntary user/ state patient/mentally ill prisoner:

.....

First name(s) of assisted user/involuntary user/state patient/mentally ill prisoner

.....

Date of birth: or estimated age:

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

Date of admission to health establishment:

The above assisted user/involuntary user/state patient/mentally ill prisoner absconded
from:(name of health establishment)

Address:

.....

.....

.....

.....

Date of abscondment:

Date of return:

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

Print Initials and Surname:

Force Number if applicable:

Date:

State physical / mental condition:

.....

.....

.....

.....

.....

.....

FORM MHCA 26

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 the Review Board and 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 Magistrate, head of the prison from where the User was initially transferred and to head of national department)

FORM MHCA 27

DEPARTMENT OF HEALTH

**GRANTING OF LEAVE OF ABSENCE TO A STATE PATIENT,
ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USERS****[Section 45, 66(1)(j) of the Act]**

Surname of assisted or involuntary mental health care user:

First name(s) of assisted or involuntary mental health care 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:

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

FORM MHCA 27

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:

FORM MHCA 28**DEPARTMENT OF HEALTH****CANCELLATION OF LEAVE OF ABSENCE OF A STATE PATIENT OR AN
ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USER****[Section 45(3), 66(1)(j) of the Act]**

I hereby cancel the leave of absence of

(name of state patient, assisted 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 detention centre)

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)

FORM 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 state patient:

First name(s) of state patient:

File No. (if known):

Date of birth: or estimated age:

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

Residential address:

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

Charge against state patient:

Person making application (mark with a cross):

State patient him/herself ☐ Head of health establishment ☐Responsible medical practitioner ☐ Spouse ☐ Associate ☐ Next of kin ☐Other ☐

Reasons for application:

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

Has an application been made for discharge of state patient within the preceding 12 months

by any application other than an official curator ad litem? Yes ☐ No ☐

FORM MHCA 29

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 state patient? 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 state patient:

.....

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:

FORM 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 state patient:

First name(s) of state patient:

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 as application been made for discharge of the state patient within the preceding 12 months by any applicant other than official *curator ad litem*?Yes ☐ No ☐

If yes, provide details of the status of that application (and no need to 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:

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

FORM MHCA 30

Recommendations and comments on whether the application should be granted:

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

Print initials and surname:

Signature:

(Official *curator ad litem*/administrator)

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 reason 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):

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

FORM MHCA 30

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 of state patient 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:

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

FORM MHCA 30

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:

.....

.....

.....

FORM MHCA 30

Recommendations:

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

Signature:
(psychiatrist / medical practitioner)

Date:

Place:

FORM MHCA 31

DEPARTMENT OF HEALTH

ORDER BY JUDGE IN CHAMBERS FOR CONDITIONAL DISCHARGE OF
STATE PATIENT

[Section 47(6)(d) of the Act]

Surname of state patient:

First name(s) of state patient:

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

(a) Remain a state patient ☐(b) Be reclassified and dealt with as a voluntary ☐ or assisted ☐ or involuntary ☐(c) Be discharged unconditionally ☐(d) Be discharged conditionally ☐

Terms and conditions for conditional discharge—

.....

.....

.....

.....

Period of conditional discharge (years)

FORM MHCA 31

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

.....

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

.....
 (name of health establishment)

The state patient 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 state patient:

.....

Name of psychiatric hospital / care and rehabilitation center where the state patient is to be admitted if s/he relapses or if the conditions of the conditional discharge are violated:

.....

Print initials and surname:

Signature:

(Judge in chambers)

Date:

Place:

FORM MHCA 32**DEPARTMENT OF HEALTH****SIX-MONTHLY REPORT ON CONDITIONALLY DISCHARGED STATE
PATIENT****[Section 48(3) of the Act]**

Surname of state patient:

First name(s) of state patient:

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 state patient is adhering to the terms and conditions
of the discharge:.....
.....
.....

Current mental health status of state patient:

.....
.....
.....Recommendation to head of health establishment from where the state patient 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)**

FORM 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 state patient:

First name(s) of state patient:

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 state patient'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 and that his / her mental health status has not deteriorated.

The above state patient is hereby unconditionally discharged.

Print initials and surname:

Signature:

(head of health establishment)

Date:

Place:

(Copy to be forwarded to the state patient, registrar of the court concerned, the official *curator ad litem* and national department)

FORM 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 state patient:
 First name(s) of state patient:
 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)

FORM MHCA 35

DEPARTMENT OF HEALTH

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

Surname of state Patient:

First name(s) of state patient:

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:

FORM MHCA 35

Decision by Judge in Chambers:

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

Print initials and surname:

Signature:

(Judge in Chambers)

Date:

Place:

**(Copy to state patient, head of health established, head of the national department,
registrar of the High Court and *curator ad litem*)**

FORM MHCA 36

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 the prisoner:

First name(s) of the prisoner:

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:

.....

.....

.....

FORM MHCA 36

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

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

Facts concerning the mental condition of the prisoner 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 prisoner—

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 ☐

FORM MHCA 36

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:

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

Print initials and surname:

Signature:

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

Date:

Place:

FORM 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 the prisoner:

First name(s) of the prisoner:

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

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:

(Copy to be forwarded to the Review Board Curator/Administrator (if appointed) and the head of the national department)

FORM MHCA 38

DEPARTMENT OF HEALTH

**APPLICATION TO MAGISTRATE FOR CONTINUED DETENTION OF A
MENTALLY ILL PRISONER**
[Sections 58(3) of the Act]

Surname of mentally ill prisoner:

First name(s) of mentally ill prisoner:

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 mentally ill prisoner 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 provided care, treatment and rehabilitation pending the outcome
of the application.

Print initials and surname:

Signature:

(head of health establishment)

Date:

Place:

FORM MHCA 39**DEPARTMENT OF HEALTH****APPLICATION TO MASTER OF HIGH COURT FOR THE APPOINTMENT OF
ADMINISTRATOR****[Sections 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).....
.....
.....

FORM MHCA 39

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:

.....

FORM MHCA 39

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:

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.

FORM MHCA 39

Print initials and surname:

Signature:

(Master of the High Court)

Date:

Place:

FORM 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)

FORM 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 relationship or capacity)

Grounds of the appeal:

.....

Facts on which the appeal is based:

.....

Print initials and surname:

Signature:

(Applicant)

Date:

Place:

FORM MHCA 42

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)

FORM MHCA 43

DEPARTMENT OF HEALTH

NOTICE 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 the 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 High Court)

Date:

Place:

FORM 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:

.....

.....

.....

.....

.....

.....

.....

FORM MHCA 44

Print initials and surname:

Signature:

(Master of High Court)

Date:

Place:

[Copy to applicant and head of health establishment]

FORM 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:

.....

Facts on which the appeal is based:

.....

Signature:

(Appellant)

Date:

Place:

(Copies to Master of High Court)

FORM 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 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

FORM MHCA 46

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)

[Regulation 36 and 37 of the Regulations]

[illegible]