



# Government Gazette Staatskoerant

REPUBLIC OF SOUTH AFRICA  
REPUBLIEK VAN SUID-AFRIKA

*Regulation Gazette*

**No. 10309**

*Regulasiekoerant*

**Vol. 593**

**Pretoria, 6 November 2014**

**No. 38182**

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## GOVERNMENT NOTICE

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### DEPARTMENT OF HEALTH

No. R. 874

6 November 2014

#### Mental Health Care Act, 2002 (Act 17 of 2002)

#### GENERAL REGULATIONS RELATING TO THE MENTAL HEALTH CARE ACT, 2002: AMENDMENT

The Minister of Health intends, in terms of Sections 66, 67 and 68 of the Mental Health Care Act, 2002 (Act No.17 of 2002), and after consultation with the members of the Executive Council to make the Regulations in the Schedule.

#### SCHEDULE

- 1 In these Regulations “the Regulations” means the General Regulations made in terms of the Mental Health Care Act, 2002 (Act No. 17 of 2002) published under Government Notice R. 1467 Gazette No 27117 of 15 December 2004, as corrected by Government Notice R. 98 Gazette No 27236 of 11 February 2005.

#### Amendment of Regulation 1 of the Regulations

#### Regulation 1 of the Regulations is hereby amended

- (a) by the insertion before the definition “**health establishment administered under the auspices of the state**”, of the following definitions:

“**custodian**” means a person who undertakes and is entrusted with the responsibility of ensuring that the conditions prescribed in terms of Sections 34(5)(a) and 45 of the Act are adhered to by the user/state patient;” and

“**Health care provider**’ has the meaning assigned to it by the National Health Act, 2003 (Act No. 61 of 2003);”

- (b) by the substitution for the definition “**health establishment administered under the auspices of the state**” of the following:

“**health establishment**’ has the meaning assigned to it in section 1 of the National Health Act, 2003 (Act No. 61 of 2003);”

- (c) by the insertion after “**maximum security**” of the following definitions:

‘**Mechanical restraint**’ means the use of any instrument or appliance whereby the movements of the body or any of the limbs of a user are restrained or impeded;

‘**non-governmental organizations**’ means non-profit, voluntary citizens’ groups which are task-orientated and driven by people with common interests and who perform a variety of services and humanitarian functions;

‘**Organ of state**’ has the meaning as assigned to it in Section 239 of the Constitution;

- (d) by the substitution for the definition of ‘**private hospital**’ for the following:

“‘**private hospital**’ has the meaning assigned to it in Section 1 of the National Health Act, 2003 (Act No. 61 of 2003);”

- (e) by the insertion after “**the Act**” of the following definition:

‘**volunteer organizations**’ means a group of individuals who enter into an agreement as volunteers to form a body (or organization) to accomplish a purpose.

#### **General amendment to the Regulations**

The Regulations are hereby amended by the substitution for the expression “**72-Hours**” of the expression “**72-hour**” wherever it appears on the said Regulations.

**Amendment of Regulation 2 of the Regulations**

Regulation 2 is hereby amended by the substitution of subregulation (2) (a) of the following subregulation:

- (a) “treated and cared for at such primary health care [facility] level health establishment; or”

**Amendment of Regulation 3 of the Regulations**

Regulation 3 is hereby amended

- (a) by the substitution of subregulation (1) of the following subregulation:

“(1) When a head of a health establishment makes a decision in terms of these Regulations that falls outside his or her scope of professional practice, he or she must act [in] after consultation with the [relevant] mental health care practitioner(s) that conducted the assessment and or any other mental health practitioner(s).”

- (b) by the substitution of subregulation (2) of the following subregulation:

(2) The duties and functions to be performed by the head of a health establishment in terms of the Act or these Regulations may in the absence of such head, be performed by the person acting as head of such a health establishment.

**Amendment of Regulation 5 of the Regulations**

Regulation 5 is hereby amended by the substitution of subregulation (2) of the following subregulation:

- "(2) Community programmes or [facilities] health establishments may be run by-

#### **Amendment of Regulation 6 of the Regulations**

Regulation 6 is hereby amended by the substitution of the following subregulation:

- "6 Within available resources the State must provide subsidies to appropriate non-profit organizations or volunteer organizations for the provision of community care, treatment and rehabilitation to meet the objectives of the Act."

#### **Amendment of Regulation 7 of the Regulations**

Regulation 7 is hereby amended

- (a) by the substitution of subregulation (1) of the following subregulation:

- "(1) A person witnessing any form of abuse, exploitation and/or degrading treatment against a mental health care user as contemplated in Section 11(1) of the Act-

- (b) by the substitution subregulation (1) (b) of the following subregulation:

- "(b) may lay a charge with the South African Police Service who shall investigate the matter and take appropriate action, and thereafter in writing notify the Review Board concerned of that charge."

- (c) by the substitution of subregulation (2) of the following subregulation:

- "(2) When a Review Board receives a report or notification contemplated in sub regulation (1) that Board must investigate that report or notification and if necessary, lay a charge with the South African Police Service and may decide to hold a complaint hearing."

(d) by the insertion of subregulation (3)

“(3) Should the Review Board decide to hold a complaint hearing, the secretariat of the Review Board must in writing and by registered post inform the complainant referred to in Section 11(2) of the Act, the relevant mental health care practitioners, the head of the health establishment concerned and any other person whom the Review Board considers to be important to the hearing of the complaint, the date of hearing and whether written or oral representation, as appropriate, must be made to the Review Board and advise of the right of representation as required.”

(e) by the insertion of subregulation (4)

“(4) The Review Board must give notice of the hearing at least two weeks before the date of such hearing.”

(f) by the insertion of subregulation (5)

“(5) The Review Board may summon any person in the form of form MHCA 18 of the Annexure to appear before it as a witness to give evidence or to produce any book, record, document or other item, which in the opinion of the Review Board is relevant to the hearing.”

### **Amendment of Regulation 10 of the Regulations**

Regulation 10 is hereby amended by the substitution of subregulation (4) of the following subregulation:

“(4) An application form contemplated to in subregulation (1) must when it has been completed, be submitted to the head of a health establishment who must cause the mental health care user to be examined by at least two mental health care practitioners in accordance with Section 33(4) of the Act.”

**Amendment of Regulation 11 of the Regulations**

Regulation 11 is hereby amended

(a) by the substitution of subregulation (2) of the following subregulation:

“(2) A registered medical practitioner conducting an assessment contemplated in Section 34 of the Act may determine the treatment programme and the place within the hospital where the mental health care user must be kept during the 72-hour[s] assessment period to ensure the safety of such user and others.”

(b) by the substitution of subregulation (3) of the following subregulation:

“(3) If the facilities at the health establishment concerned are unsuitable for the 72-hour[s] assessment or personnel within that health establishment are unable to cope with a mental health care user due to the potential harm which that user may inflict on himself, herself, others or property if he or she remains in that health establishment, that health establishment must transfer that user to another health establishment with suitable personnel or facilities to conduct the assessment. The time period for the 72-hour assessment shall not be more than 72-hour irrespective of transfers or interruptions.”

(c) by the substitution of subregulation (4) of the following subregulation:

“(4) The registered medical practitioner contemplated to in subregulation (2) must make a provisional diagnosis of any mental illness and initiate treatment according to standard treatment guidelines or protocols as soon as possible.”

(d) by the substitution of subregulation (5) of the following subregulation:



“(5) A registered medical practitioner must monitor the physical and mental condition of the mental health care user closely and give a written report to the head of the health establishment concerned on such user's mental status at least every 24 hours during the 72-hour assessment period.”

(e) by the substitution of subregulation (6) of the following subregulation:

“(6) The registered medical practitioner and another mental health care practitioner who conducted 72-hour[s] assessment must within 12 hours after the expiry of the 72-hour[s] assessment period each submit a [joint] written report in the form of form MHCA 06 of the Annexure to the head of the health establishment concerned, indicating [their] his/her assessment on the physical and mental health status of the mental health care user and [their] his/her recommendations concerning further treatment.”

### **Amendment of Regulation 12 of the Regulations**

Regulation 12 is hereby amended

(a) by the substitution of subregulation (2) (a) of the following subregulation:

“(1) The head of a provincial department must submit to all health establishments **[under the auspices of the State, private health establishments]** within the province concerned, the South African Police Service and the national department a list of the health establishments in each district in that province that provide the 72-hour assessments contemplated in Section 34 of the Act.”

(b) by the substitution of subregulation (2) (a) of the following subregulation:

“(2) The head of such provincial department must update and publish in the Government Gazette the list contemplated in subregulation (1) on an annual basis indicating which health establishment falls in which district and submit that updated list to the bodies referred to in subregulation (1).”

**Amendment of Regulation 13 of the Regulations**

Regulation 13 is hereby amended by the substitution of subregulation (2) of the following subregulation:

“(2) An appeal contemplated [to] in Section 29(1) of the Act may be-“

**Amendment of Regulation 17 of the Regulations**

Regulation 17 is hereby amended by the substitution of the following subregulation:

“17 The head of a health establishment must in terms of Section 16, 31(3)(a), 34(5)(a), 48(4)(a) [or] and 56(a) of the Act issue a discharge report [in the form] by way of form MHCA 03 of the Annexure.”

**Amendment of Regulation 18 of the Regulations**

Regulation 18 is hereby amended:

(a) by the substitution of subregulation (2) of the following subregulation:

“(2) The schedule of conditions contemplated in subregulation (1) must be read and explained to the mental health care user and to his or her custodian or read and translated into one of the official languages that such user can understand.”

(b) by the substitution of subregulation (9) of the following subregulation:

“(9) Where a mental health care user does not present himself or herself for monitoring and review according to the conditions referred to in subregulation (1), and after the necessary measures have been taken by the health establishment concerned to locate such user, such user must be deemed to have absconded in terms of Section 40(4) of the Act and in

such a case the health establishment concerned must inform the South African Police Service in the form of form MHCA 25 of the Annexure.”

#### **Amendment of Regulation 19 of the Regulations**

Regulation 19 is hereby amended by the substitution of the following subregulation:

- “19 Arrangement for a transfer contemplated Section 34(4)(b) of the Act must be made in accordance with form MHCA 11 of the Annexure between the head of the psychiatric hospital, care and rehabilitation center concerned and the head of a health establishment where the involuntary mental health care user is currently admitted.”

#### **Amendment of Regulation 20 of the Regulations**

Regulation 20 is hereby amended by the substitution of subregulation (1) of the following subregulation:

- “(1) Where required in terms of Sections 8(3) or [~~34(5) or (6)~~] 34(4), 34(5) or 34(6) of the Act, a mental health care user may be transferred from inpatient to outpatient care and vice versa, using form MHCA 12 of the Annexure.”

#### **Amendment of Regulation 21 of the Regulations**

##### **Regulation 21 is hereby amended**

- (a) by the substitution of subregulation (1) (a) of the following subregulation:

- “(1) A periodic review [~~on~~] must be done by-

- (a) an assisted mental health care user in terms of Section 30 of the Act using form MHCA 13 A;

- (b) an involuntary mental health care user in terms of Section 37 of the Act using form MHCA 13A;
  - (c) a state patient in terms of Section 46 of the Act using form MHCA 13B;
  - (d) a mentally ill prisoner in terms of Section 55 of the Act using form MHCA 13A. **[must be done on form MCHA 13 of the Annexure]**”
- (b) by the substitution of subregulation (2)(a) of the following subregulation:
  - “(a) the first review must be done by a psychiatrist or registered medical practitioner six months after the commencement of care, treatment and rehabilitation services;”
- (c) by the substitution of subregulation (2) (c) of the following subregulation:
  - “(c) the reviews thereafter must be done every 12 months, provided that every alternate review shall be done by a psychiatrist or registered medical practitioner.”
- (d) by the substitution of subregulation (3) of the following subregulation:
  - “(3) With regard to a person referred to in subregulation (1)(d) periodic reviews must be done every six months by a psychiatrist or a registered medical practitioner.”

### **Amendment of Regulation 23 of the Regulations**

Regulation 23 is hereby amended by the insertion of subregulation (3) of the following subregulation:

- “(3) Arrangements for the transfer of a mental health care user to another health establishment must be made between the heads of the two health establishments concerned.”

#### **Amendment of Regulation 25 of the Regulations**

Regulation 25 is hereby amended by the substitution of subregulation (1) of the following subregulation:

- “(1) The head of the national department of **[Health] health** must immediately after receipt of an order referred to in Section 42(1) of the Act make arrangements in terms of Section 42(3) of the Act in the form of form MHCA 23 of the Annexure for the transfer of the State patient concerned from the detention center to the health establishment designated in terms of Section 41 of the Act.”

#### **Amendment of Regulation 29 of the Regulations**

Regulation 29 is hereby amended

- (a) by the substitution of the heading of the following heading:

**Return of an absconded person who has been apprehended and is being held in custody by the South African Police Service**

- (b) by the substitution of subregulation (4) of the following subregulation:

- “(4) The head of the health establishment contemplated in subregulation (1) must, if circumstances so require, take steps to ensure that a mental health care practitioner from a health establishment nearest to the police station where the mental health care user is held in custody or another suitable mental health care practitioner, examines that mental health care user and provides the treatment that may be required at the police station or the nearest local health establishment.”

**Amendment of Regulation 30 of the Regulations**

Regulation 30 is hereby amended

- (a) by the substitution of the heading of the following heading:

**“Application for discharge [Discharge] of State patient”**

- (b) by the substitution of subregulation (3) of the following subregulation:

“(3) On considering an application, the judge in chambers may make an order in the form of form MHCA 31 of the Annexure that the State patient-

- (a) remain a state patient; or
- (b) be reclassified; or
- (c) be discharged conditionally; or
- (d) be discharged unconditionally.”

**Amendment of Regulation 32 of the Regulations**

Regulation 32 is hereby amended

- (a) by the insertion of subregulation (4) of the following subregulation:

“(4) Psycho-surgery shall be approved by the provincial head of health after duly considering the reports referred to in sub-Section 32(2).”

**Amendment of Regulation 33 of the Regulations**

Regulation 33 is hereby amended

(a) by the substitution of subregulation (1) of the following subregulation:

“(1) Electro-convulsive treatment must be conducted by a psychiatrist or a registered medical practitioner with special training in mental health and may only be carried out under a general anaesthetic together with a muscle relaxant.”

(b) by the substitution of subregulation (4) of the following subregulation:

“(4) A health establishment that wishes to **[under the auspices of the State or a private health establishment may only]** perform electro-convulsive treatment must apply in writing and shall be authorized by the provincial head of **[the provincial]** department concerned.”

(c) by the substitution of subregulation (5) of the following subregulation

“(5) Whenever electro-convulsive treatment is performed a register kept for that purpose must be signed and completed by the relevant psychiatrist or registered medical practitioner and a transcript of the register must be submitted by the health establishment concerned to the Review Board on a quarterly basis in the form of form MHCA 47 of the Annexure to give effect to Section 19(1) (b) of the Act.”

### **Amendment of Regulation 35 of the Regulations**

Regulation 35 is hereby amended by the substitution of subregulation (2) of the following subregulation:

“(2) Where a **[mental health care]** registered medical practitioner deems a user to be incapable of consenting to treatment or an operation due to mental illness or intellectual disability, **[then a curator, if a court has appointed one, a spouse, next of kin, a parent or guardian, a child over the age of 18, a brother or sister, or a partner or associate may**

**consent to the treatment or operation.] informed consent must be obtained in accordance with current statutory requirements.** “

#### **Amendment of Regulation 36 of the Regulations**

##### **Regulation 36 is hereby amended**

- (a) by the substitution of subregulation (3) of the following subregulation:

“(3) While the mental health care user is under restraint, he or she must be subject to observation [**at least every 30 minutes**] as prescribed by the psychiatrist or registered medical practitioner and such observations should be recorded in the clinical notes.”

- (b) by the substitution of subregulation 4 (a) of the following subregulation:

“(a) a register kept for that purpose must be signed and completed by the relevant registered medical practitioner;”

- (b) by the substitution of subregulation 4 (b) of the following subregulation:

“(b) the form of mechanical means of restraint, the time period used, the times when the mental health care user was observed and the reason for administering such means of restraint must be outlined by the psychiatrist or registered medical practitioner in the register contemplated in paragraph (a); and”

#### **Amendment of Regulation 37 of the Regulations**

##### **Regulation 37 is hereby amended**

- (a) by the substitution of subregulation (1) of the following subregulation:



“(1) [A mental health care user may not be secluded as a punishment and seclusion] Seclusion of a mental health care user may-

(a) [may] only be used to contain severely disturbed behaviour, which is likely to cause harm to self, others or property.

(b) [seclusion may] not be used as a punishment.”

(b) by the substitution of subregulation (2) of the following subregulation

“(2) While a mental health care user is secluded, he or she must be subject to observation [at least every 30 minutes] as prescribed by the psychiatrist or a registered medical practitioner and that observation should be recorded in the clinical notes.”

(c) by the substitution of subregulation (3) (a) of the following subregulation

“(a) a register, signed by a registered medical practitioner, must be completed;”

(d) by the substitution of subregulation (3) (b) of the following subregulation:

“(b) the time period that the mental health care user concerned needed to be secluded and the reason for secluding that mental health care user must be outlined and the seclusion must be [outlined] recorded in the relevant register by the registered medical practitioner; and”

### **Amendment of Regulation 38 of the Regulations**

Regulation 38 is hereby deleted.

### **Amendment of Regulation 39 of the Regulations**

Regulation 39 is hereby amended by the substitution of the following subregulation:

“39 The following records must be kept in a health establishment that **[provides mental health care, treatment and rehabilitation]** is designated to serve as a psychiatric hospital or care and rehabilitation centre in terms of Section 5 of the Act.”

#### **Amendment of Regulation 42 of the Regulations**

Regulation 42 is hereby amended

(a) by the substitution of subregulation (3) (a) of the following subregulation

“(a) the mental health care practitioners who are involved in the procedures relating to Sections 27 and 33 of the Act **[examine assisted or involuntary mental health care users in terms of Section 27 and 33 of the Act will not be employed by as staff at that hospital and will]** will have no material or financial interest in that hospital;”

(b) by the substitution of subregulation (4) (b) of the following subregulation

“(b) suitable mental health care practitioners, including **[at least one]** a psychiatrist, as well as other trained staff deemed necessary to carry out all necessary duties in accordance with the minimum norms and standards of the Department of Health;”

(c) by the substitution of subregulation (5) of the following subregulation

“(5) The conditions of a licence contemplated in subregulation (2) must be clearly stipulated by the **[provincial]** national department **[concerned]**, and must include-”

(d) by the substitution of subregulation (6) of the following subregulation

- “(6) If a condition of a licence contemplated in subregulation (5) is not complied with, the [national] provincial department [concerned] may withdraw that [a] licence.”

### **Amendment of Regulation 43 of the Regulations**

Regulation 43 is hereby amended

- (a) by the substitution of subregulation (1) of the following subregulation

- “(1) Any service [not directly run under the auspices of an organ of State and] which is not a designated psychiatric hospital or care and rehabilitation centre, but which provides residential or day-care facilities for 5 people or more with mental disorders must in terms of the Act—”

- (b) by the substitution of subregulation (2) of the following subregulation

- “(2) The conditions of a licence contemplated in subregulation (1) must be clearly stipulated by the [national] provincial department concerned and must include—”

### **Amendment of Regulation 44 of the Regulations**

Regulation 44 is hereby amended:

- (a) by the substitution of subregulation (1) of the following subregulation

- “(1) The [National] Department of Education shall be responsible for the establishment of educational programmes of learners in the compulsory age group or those entitled to basic education programmes.”

- (b) by the deletion of subregulation (2)

- (c) by the deletion of subregulation (3)

- (d) by the deletion of subregulation (4)
- (e) by the deletion of subregulation (5)

#### **Amendment of Regulation 46 of the Regulations**

Regulation 46 of the Regulations is hereby amended by the substitution of the heading of the following heading:

**“Payment of maintenance costs and expenses in [facilities run under auspices of the State] health establishments.”**

#### **Amendment of the annexures to the Regulations**

Annexures are hereby substituted of the following annexures:

**“ANNEXURES****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 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: .....

## 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/We.....  
(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:

(where known)

Surname user .....

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

Gender: Male ☐ Female ☐

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

Residential address: .....

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

Name of health establishment or other place where exploitation, physical or other abuse, neglect or degrading treatment occurred .....

Address: .....

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

Brief description of the user:

.....  
.....

Description of exploitation, physical or other abuse, neglect or degrading treatment:

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

[Original copy 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 .....

ID Number: .....

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

Gender: Male ☐ Female ☐

Name of institution: .....

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 AND SURNAME)**

**Name and surname 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: .....

.....

.....

**B. INFORMATION REGARDING APPLICANT**

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: .....

.....  
 .....

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

Spouse ☐ Next of kin ☐ Partner ☐ Associate ☐

Guardian ☐ Health care provider ☐ Parent ☐

(If user is under 18 this application must be made by the parent, caregiver, guardian or person with parental right and responsibilities)

I last saw the user on ..... at

.....  
 (date) (time) (place).....

(The applicant must have seen the user within seven days of making this application)

**D. Why is the applicant the health care provider?:**

The spouse, next of kin, partner, associate, parent or guardian of the user is:

(i) Unwilling (State reasons for this conclusion):

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

or

(ii) Incapable (State Reasons for this conclusions for this conclusion):

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

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?):

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

**E. 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 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 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: ☐ .....  
 .....  
 .....

I wish to have representation/Legal Representation/ Legal Aid

Yes ☐ No ☐

for myself or on behalf of.....

Print initials and surname.....

Signature (Applicant):.....

Date: .....

Place: .....

Note: Applicant must sign under oath

#### F. OATH/AFFIRMATION

SIGNED AND SWORN to, before me, at \_\_\_\_\_ on this the \_\_\_\_\_ day of \_\_\_\_\_ 20...., by the deponent who has acknowledged that s/he understands the contents of this affidavit, has declared that s/he has no objection to taking the oath, that s/he considers the oath to be binding on her/his conscience and s/he uttered the following words" "I swear that the contents of this affidavit are true, so help me God."

\_\_\_\_\_  
 COMMISSIONER OF OATHS

## 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: .....

.....

.....

.....

.....

**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 ☐

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):

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

**Section 4**

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

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

**Section 5**

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

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

**Section 6**

Type of illness (provisional diagnosis):

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

**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 **(do not complete section 9 of this form if section 8 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 is capable of making an informed decision on the need 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 **(Do not complete section 8 of this form if section 9 is applicable)**

1. Is the user suffering from a mental illness and as a consequence of this requires care, treatment and rehabilitation services? 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. 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 have his/her financial interests or reputation safeguarded and his/her right to have an administrator or curator appointed.

Comment:

.....  
 .....

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 INVOLUTARY 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 registered medical practitioners only):  
 .....  
 .....  
 .....

(b) Are there signs of injuries? Yes ☐ No ☐  
 If yes, please indicated whether you believe this is as a result of abuse?  
 Yes ☐ No ☐  
 If yes, was this abuse reported/investigated? Yes ☐ No ☐

(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:

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

#### 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 ☐

Is the care, treatment and rehabilitation, in your view necessary for the user's financial interests and reputation? Yes ☐ No ☐

#### Section 8

Based on the abovementioned information my recommendation to the head of health establishment is that the user should either:

1. Receive voluntary care, treatment and rehabilitation service ☐

or

2. Receive assisted care, treatment and rehabilitation services ☐

or

3. Continue to receive involuntary in-patient care, treatment and rehabilitation services ☐  
 or  
 4. Receive involuntary out-patient care, treatment and rehabilitation services ☐  
 or  
 5. Be discharged from the Mental Health Care Act ☐

**Section 9**

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

Comment:.....  
 .....  
 .....  
 .....  
 .....

**Section 10**

Print initials and surname;.....

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 ..... hereby

Consent ☐do not consent ☐

(name of head of health establishment): .....  
to the assisted care, treatment and rehabilitation ☐ 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, mental health care user 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]**

I. .... hereby  
request.....(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 ☐ / not 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: .....

(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 user)

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

I am satisfied / not satisfied (tick box) 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 Review Board]

**FORM MHCA 10**

**DEPARTMENT OF HEALTH**

**TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER -  
SCHEDULE OF CONDITIONS RELATING TO HIS OR HER 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: .....

.....

.....

.....

.....

The user's mental health status will be monitored and reviewed at .....  
..... (name of health establishment)

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

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: .....

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

.....

.....

.....

.....

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)

Print initials and surname .....

.....

Signature(head of health establishment)

Date: .....

Place: .....

.....

Signature of user (understand and accept the stipulated conditions)

.....

Signature of custodian (understand and accept the stipulated conditions)

[Copy to Review Board, 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]

..... an assisted ☐ or  
involuntary ☐ (name and surname of user)  
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

**TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER FROM  
INPATIENT TO OUTPATIENT CARE AND VICE VERSA  
[Section 34(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 ☐

Residential address: .....

.....

.....

.....

.....

Transfer from inpatient to outpatient care

This involuntary inpatient at .....  
(name and health establishment) has improved / altered to such an extent that s/he 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.

Transfer from outpatient to inpatient care

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:

.....

.....

.....

.....

Physical condition of user:

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

Diagnosis:

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

**Section 3 Planning**

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:

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

Psychological:

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

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

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

Occupational:

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

Physiotherapy (if required):

.....  
.....

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

**Family contracts:**

Personal ☐ Correspondence ☐ Regular ☐ Seldom ☐ Never ☐

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

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

**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 outpatient involuntary care?

Yes ☐ No ☐

Briefly motivate:

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

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

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

.....  
Print initials and surname of assessing practitioner: .....

Signature:.....

(assessing practitioner)

Date: .....

Place: .....

Instructions and remarks:

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

Signature:.....

(head of health establishment)

Date: .....

Place: .....

'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 user .....

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

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

Gender:      Male ☐      Female ☐

Name of health establishment concerned: .....

Registration number (if any): .....

Date of first admission of mental health care user 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:

.....

.....

.....

.....

Since admission / previous report:

.....

.....

.....

.....

Present mental status:

.....

.....

.....

.....

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

.....

.....

.....

.....

Present physical condition:

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

Diagnosis at present date:

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

**Family contracts:**

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:

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

Should the user be discharged conditionally? Yes ☐ No ☐

Comment:

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

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

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

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



[illegible]

Date: .....  
Place: .....

.....

.....

.....

.....

Date: .....  
Place: .....

.....

.....

.....

## Recommendations:

(a) Further care and treatment:

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

b) Leave of absence (State patients):

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

(c) Discharge of user:

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

Signature:.....

(head of national department):

Date: .....

Place: .....

[Copy to be sent back to 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.

**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 decides that—

- (a) the user should be discharged from a health establishment ☐ or
- (b) the user should receive care, treatment and rehabilitation services as a voluntary user ☐ or
- (c) the user should receive care, treatment and rehabilitation services as an assisted inpatient ☐ or
- (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 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 ☐ Partner ☐ Associate ☐Next of kin ☐ Parent ☐ Guardian ☐

## Grounds for the appeal:

.....

.....

.....

.....

.....

.....

## Facts on which the appeal is based:

.....

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

I, the undersigned wish to have representation/Legal Representation/Legal Aid  
for myself or on behalf of .....(put in a tick box for 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 ...../('s)

(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.

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 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 (Specify) ☐

The Review Board has decided/recommended that:

- (a) the user should be discharged ☐ or
- (b) the user should receive care, treatment and rehabilitation services as a voluntary user ☐ or
- (c) the user should receive care, treatment and rehabilitation services as an assisted inpatient ☐ or



(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 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.

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 PATIENT/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 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: .....

**FORM MHCA 20****DEPARTMENT OF HEALTH****ORDER BY REVIEW BOARD TO TRANSFER PATIENT/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 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 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:

.....

.....

.....

.....

.....

.....

.....

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]

## 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 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]

## 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 INFLECT 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: .....

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 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 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 BETWEEN DESIGNATED HEALTH  
ESTABLISHMENTS

[Sections 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 to 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)

(y) form MHCA 25 is hereby substituted with the following form:

## 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 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 ☐ Mental 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 ☐

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 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 USER**  
**[to be completed by the head of Health Establishment]**

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):

Print Initials and Surname:.....

Force Number if applicable:.....

Date:.....

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 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 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: .....

## 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, 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 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 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 ☐ 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 ☐

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 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 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

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):

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

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:

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

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)

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: .....

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:

.....

.....

.....

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 ☐

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)  
.....  
.....  
.....

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 father 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:  
 .....

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: .....

**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 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 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:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

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  
 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: .....

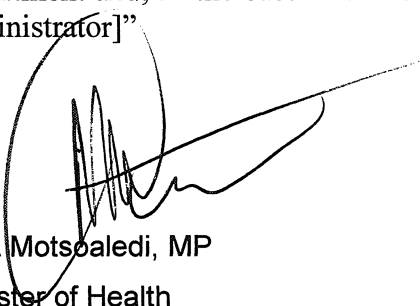
Signature: .....

(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]"



Dr A Motsaedi, MP  
Minister of Health

**NOTICE – CHANGE OF TELEPHONE NUMBERS: GOVERNMENT PRINTING WORKS**

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The numbers for our provincial offices in Polokwane, East London and Mmabatho will not change at this stage.

Printed by and obtainable from the Government Printer, Bosman Street, Private Bag X85, Pretoria, 0001  
Publications: Tel: (012) 748 6052, 748 6053, 748 6058

Advertisements: Tel: (012) 748 6205, 748 6208, 748 6209, 748 6210, 748 6211

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