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ACT Health

Community/Forensic Community Care Order - Care Plan - Care Coordinator's Determination

Mental Health Act 2015

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

Requirement under Section:

☐ 70 (2) Role of the Care Coordinator for a Community Care Order - determination

OR

☐ 110(2) Role of the Care Coordinator for a Forensic Community Care Order - determination

Name of person: _____

Date of birth: _____

Residential address: _____

Guardian: _____

Case manager/s: _____

Agency and region: _____

Date of Order: ____ /____ /_____ Reference number: _____

Times and the place of care, treatment and support: [detail nature of medication prescribed by a doctor, care, support and any counselling, training, therapeutic or rehabilitation programs] [attach a separate page if necessary]

_____

_____

_____

_____

_____

Residential location: [include any housing issues]

_____

_____

_____

_____

_____

_____

Please email signed form to ACATMentalHealth@act.gov.au or fax 6217 4505
and
The public advocate pa@act.gov.au or fax 6207 0688
A copy of the determination must also be provided to all persons consulted

Community/Forensic Community Care Order - Care Plan - Care Coordinator's Determination

Is there a Restriction Order? ☐ Yes ☐ No

The nature as stated in the Restriction Order (Section 69 Mental Health Act 2015) [attach a separate page if necessary]

Is there a directive for the person to be detained at a stated approved community care facility (Section 109 (e)(ii)? ☐ Yes ☐ No

Provide details:

Before making this determination:

☐ I have consulted with the person and their views are: _____

OR

☐ I have not consulted the person due to the following reasons: _____

I have consulted each person with parental responsibility (if the person is a child)	☐ Yes	☐ No	☐ N/A
I have consulted the Guardian (if the person has a guardian)	☐ Yes	☐ No	☐ N/A
I have consulted the Attorney (Under Powers of Attorney Act 2006)	☐ Yes	☐ No	☐ N/A
I have consulted the Carer (if applicable)	☐ Yes	☐ No	☐ N/A
I have consulted the Nominated Person	☐ Yes	☐ No	☐ N/A
I have consulted the Health Attorney	☐ Yes	☐ No	☐ N/A

Signature of delegate:

Print name: _____ **Designation:** _____

Agency: _____ **Date:** ____ /____ /_____

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