

URN: \_\_\_\_\_

Family name: \_\_\_\_\_

Given names: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

**UNAUTHORISED LEAVE FROM AN INPATIENT FACILITY RISK ASSESSMENT**



\* 7 5 2 5 3 5 2 5 \*

**Section 1. Health Facility Absconded from (tick)**

- Adult Mental Health Unit, The Canberra Hospital
- Mental Health Short Stay Unit, The Canberra Hospital
- Adult Mental Health Rehabilitation Unit, University of Canberra Hospital
- Older Persons Inpatient Unit, Calvary Health Care
- Adult Mental Health Unit - Calvary Hospital, Bruce
- Extended Care Unit
- Dhulwa Mental Health Unit
- Other (please specify): \_\_\_\_\_

Date and time unauthorised leave started: \_\_\_\_\_

Circumstances surrounding the leave: \_\_\_\_\_

**Section 2. Patient Particulars**

Other names / Alias: \_\_\_\_\_

Admission date: \_\_\_\_\_

Residential address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Clinically managed by mental health services?  Yes  No Team: \_\_\_\_\_

Subject to a Psychiatric Treatment Order, Emergency detention, Community Care Order, S.309 or Custodial Order?  Yes  No

If yes, type and date of expiry of the order: \_\_\_\_\_

**Section 3. Health Facility Information**

Reporting person's name: \_\_\_\_\_

Designation: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone number: \_\_\_\_\_

Action taken by staff to locate the patient: \_\_\_\_\_

**Section 4. Next of Kin Details**

Informed:  Yes  No

By whom: \_\_\_\_\_

On what date: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Are there children involved and who may be at risk? \_\_\_\_\_

DO NOT WRITE IN THIS BINDING MARGIN

UNAUTHORISED LEAVE FROM AN INPATIENT FACILITY RISK ASSESSMENT

35257

35257(10/19)

**Section 5. Details of Known Patient Risk**

Currently suicidal?  Yes  No

*Details:*

Currently at risk of serious self-harm?  Yes  No

*Details:*

Currently at risk of violence toward others?  Yes  No

*Details:*

Life threatening medical issues?  Yes  No

*Details:*

Other Details:

ESTIMATED LEVEL OF RISK  Moderate  Moderate to high  
(following discussion with the treating team) (tick)  High  Extreme

*Additional notes:*

**Section 6. Legal Status and Options for the Safe Return of the person**

**N.B. If the person is on an S.309 or Custodial Order (s.54) the AFP must be notified and asked to assist to return the person (see alert page 1).**

**Psychiatric Treatment Order or Community Care Order**

Is the person to be apprehended and returned to the inpatient facility pursuant to one of these types of Orders?  Yes  No

(Treatment Plan and Location Determination form must be attached)

**Other Options**

Are there any other expectations of police if and when the individual is located (e.g., general welfare check and notification to Access Mental Health or HAART or Community Recovery Service follow up)?

Yes  No

*Details:*

+

+

DO NOT WRITE IN THIS BINDING MARGIN

+

+

35257(1019)

URN: \_\_\_\_\_

Family name: \_\_\_\_\_

Given names: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

**UNAUTHORISED LEAVE FROM  
AN INPATIENT FACILITY RISK  
ASSESSMENT**

**Section 7. Patient Description**

<b>Height (cm):</b>		<b>Weight (kg):</b>			
<b>Build:</b>	<input type="checkbox"/> Medium	<input type="checkbox"/> Muscular	<input type="checkbox"/> Obese	<input type="checkbox"/> Solid	<input type="checkbox"/> Thin
<b>Hair:</b>	<input type="checkbox"/> Black	<input type="checkbox"/> Blonde	<input type="checkbox"/> Brown	<input type="checkbox"/> Coloured	<input type="checkbox"/> Fair
	<input type="checkbox"/> Grey	<input type="checkbox"/> White	<input type="checkbox"/> Red/ginger	<input type="checkbox"/> Light brown	<input type="checkbox"/> Bald/shaved
<b>Eyes:</b>	<input type="checkbox"/> Black	<input type="checkbox"/> Blue	<input type="checkbox"/> Blue/grey	<input type="checkbox"/> Brown	<input type="checkbox"/> Green
	<input type="checkbox"/> Hazel	<input type="checkbox"/> Other:			
<b>Complexion:</b>	<input type="checkbox"/> Acne/spotted	<input type="checkbox"/> Black	<input type="checkbox"/> Dark brown	<input type="checkbox"/> Fair	<input type="checkbox"/> Freckled
	<input type="checkbox"/> Medium	<input type="checkbox"/> Olive	<input type="checkbox"/> Tanned	<input type="checkbox"/> Other:	
<b>Cultural Background:</b>	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Black/African		<input type="checkbox"/> Asian	
	<input type="checkbox"/> Indian/Pakistani	<input type="checkbox"/> White/European		<input type="checkbox"/> Mediterranean	
	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Pacific Islander		<input type="checkbox"/> South American	
<b>Distinguishing Features:</b>	Scars:				
	Tattoos:				
	Disability:				
	Other:				
<b>Last known address:</b>					
<b>Access to transport:</b>					
<b>Last known contact number/s:</b>					

DO NOT WRITE IN THIS BINDING MARGIN