**Substance Addiction (Compulsory Assessment and Treatment) Act 2017**

**Note**: All section references are to the Substance Addiction (Compulsory and Treatment) Act 2017

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| **Leave of Absence**(Section 39) (1) The responsible clinician may permit the patient to be absent from a treatment centre for any period, and on the conditions, that the  responsible clinician thinks fit. (2) Permission may be given on any grounds the responsible clinician thinks fit, including, for example, compassionate grounds or that the  patient requires medical treatment. (3) The responsible clinician must not permit the absence unless the responsible clinician is satisfied that, as far as is practicable, adequate  measures have been taken to prevent the patient from causing harm to himself or herself. |  |
|  |  |
| To: [Name of the patient] |
| **Name and contact details of person to whom this leave of absence relates** |
| Last name |  | First name |
|       |  |       |
| Date of birth |  NHI |  Phone number |
|   |   |   |   |   |   |   |   |  |   |   |   |   |   |   |   |  |   |   |   |   |   |   |   |   |   |   |   |
| Address (address at time of CTO) |  | Postcode |
|       |  |   |   |   |   |
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| **Details of leave of absence** |

 You are granted leave of absence from [name and address of treatment centre] for [period of hours/days].

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| [Brief explanation for reason for leave of absence] |

 Your leave starts on [date/time] and ends on [date/time].

 You must return to [name of treatment centre] on [date/time].

 Your leave is subject to the following terms and conditions:

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| [Clearly specify, eg location, conditions, responsibilites] |

If you remain absent from [name of treatment centre] when your leave expires, I can ask an authorised officer to take all reasonable steps to return you.

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| **Contact details and signature of the responsible clinician** |
| Last name |  | First name |
|       |  |       |
| Address |  | Postcode |
|       |  |   |   |   |   |
|  |  |
| Email address |  | Contact phone number |
|       |  |   |   |   |   |   |   |   |   |   |   |   |   |

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|  |  |   |   |   |   |   |   |   |   |
| Signature of responsible clinician |  | Date |