|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance Addiction (Compulsory Assessment and Treatment) Act 2017**  **Clinical Review of Patient** (Section 42 of the Act) | | | | | | | | | | |  | | | | | |
| To: The Director of Area Addiction Services at [location] | | | | | | | | | | | | | | | | |
| **Contact information of the patient** | | | | | | | | | | | | | | | | |
| Last name | | | | | | | | |  | First name | | | | | | |
|  | | | | | | | | |  |  | | | | | | |
| Date of birth | | | | | | | |  | | | | | | | | |
|  |  |  |  |  |  |  |  |  | | | | | | | | |
| Address | | | | | | | | | | | |  | Postcode | | | |
|  | | | | | | | | | | | |  |  |  |  |  |
|  |  | | | |

The patient is subject to a compulsory treatment order made under section 32 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, which commenced on [start date] and expires on [end date].

I have examined the patient and consulted with other health professionals engaged in the treatment and care of the patient. I have taken the views of those health professionals into account in assessing the results of my review of the patient’s condition.

In my opinion [patient's name] is:

fit to be released from compulsory treatment status

**OR**

**not** fit to be released from compulsory treatment status.

I shall send a copy of this certificate to each of the following: *(tick as applicable)*

the patient

the patient’s principal caregiver

any welfare guardian of the patient (if the Court has nominated one)

the patient’s nominated person (if the patient has nominated one)

any person who is a guardian of a child of the patient

any agency involved in providing relevant services to the patient

a district inspector.

I shall be sending a copy of this certificate to the Director of Area Addiction Services, together with any other relevant reports relating to the patient’s care and treatment.

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

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