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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance Addiction (Compulsory Assessment and Treatment) Act 2017**  **Leave of Absence** (Section 39 of the Act) | | | | | | | | | |  |
| To: [Name of patient] | | | | | | | | | | |
| Date of birth |  |  |  |  |  |  |  |  |

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

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:

|  |
| --- |
| [Clearly specify] |

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.

This leave is approved by:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 clinician responsible |  | Date | | | | | | | |