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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:

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| [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:

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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 clinician responsible |  | Date |