

**I N S T R U C T I O N S**

This form must be completed by the physician following examination of the patient to assess his/her mental condition.

If recommending an assessment, copies of this form must be provided to the:

- Chief Executive Officer, Whitehorse General Hospital;
- patient;
- nearest relative, proxy or guardian if available; and
- Capability and Consent Board (fax 867-633-6954)

If patient is released, a copy of this form must be provided to the:

- Capability and Consent Board (fax 867-633-6954)

If travel is required, an Application for Medical Travel must accompany this form to Whitehorse General Hospital.

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**IN THE MATTER OF** the *Mental Health Act*

**AND IN THE MATTER OF** \_\_\_\_\_, hereinafter called the patient.  
Name of person

I, \_\_\_\_\_, a medical practitioner licensed to  
practise in the Yukon Territory, personally examined the patient, whose usual place of residence is  
\_\_\_\_\_, on \_\_\_\_\_  
Date (day/month/year)  
at \_\_\_\_\_ in \_\_\_\_\_, Yukon.  
Time (a.m./p.m.)

**1. Pursuant to sections 5 and 10 of the *Mental Health Act*, I undertook careful inquiry into the facts necessary to form a belief about the presence, nature and degree of severity of mental disorder at the time of assessment. The results of assessment are as follows:**

*Describe affective, cognitive and behavioural presentation of the patient upon interview/examination such as attitude, general appearance, motor behaviour, speech, emotional state, thought processes, thought content, perceptions, intellectual functioning, insight, judgment and diagnosis:*

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Check here if appending a copy of your admitting history as evidence for your opinions; the original is to be filed on the patient's medical record.



**4. Select A or B or C**

**A** It is my opinion that at this time the patient is not suffering from a mental disorder and should be released.

**OR**  **B** It is my opinion that at this time the patient is suffering from a mental disorder and, further, it is my opinion that the patient is **not** likely to cause bodily harm to himself or herself or any other person as a result of the mental disorder **nor** is the patient likely to suffer impending serious physical impairment as a result of the mental disorder and should be released.

**OR**  **C** It is my opinion the patient is suffering from a mental disorder. Further, I believe on reasonable grounds that the person, as a result of a mental disorder is:

threatening or attempting to cause bodily harm to himself or herself or has recently done so **AND** is likely to cause bodily harm to himself or herself, on the grounds that:

Provide evidence in support of your opinion

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR**  behaving violently towards another person or has recently done so **AND** is likely to cause bodily harm to another person, on the grounds that:

Provide evidence in support of your opinion

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR**  causing another person to fear bodily harm or has recently done so **AND** is likely to cause bodily harm to another person, on the grounds that:

Provide evidence in support of your opinion

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR**  showing or has recently shown a lack of ability to care for himself or herself **AND** is likely to suffer impending serious physical impairment, on the grounds that:

Provide evidence in support of your opinion

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AND** Based on the information recorded on this form, I recommend that the patient be involuntarily psychiatrically assessed in \_\_\_\_\_

Name of designated facility

**DATED** at \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_ month, \_\_\_\_\_ year.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
PRINTED NAME OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF WITNESS