Yukon
Health and Social Services
Capability and Consent Board

Form 13
MENTAL HEALTH ACT
Section 24

NOTICE OF INTENTION TO TRANSFER AN INVOLUNTARY PATIENT (YUKON RESIDENT)

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

This form must be completed by the attending physician **or** the two physicians who completed Form 7 (Certificate of Involuntary Admission) for the patient.

Copies of this form must be provided to the:

- ☐ Capability and Consent Board (fax 867-633-6954);
- ☐ Chief Executive Officer, Whitehorse General Hospital;
- ☐ Director of Insured Health Services;
- ☐ patient, if he/she is competent to consent; and
- ☐ substitute decision-maker, if the patient is not competent to consent to the transfer.

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,

hereby give notice to the Yukon Capability and Consent Board of the intention to transfer the patient, a resident

of the Yukon, to ______________________________________, a provincially approved facility located at
Name of facility

____, in the province of ______________________________

on or about ____.
Date (day/month/year)

The patient will be under the care of____.
Attending physician, if known

The following are the facts upon which I formed the opinion as to the need to transfer the patient to the above-

named facility ____

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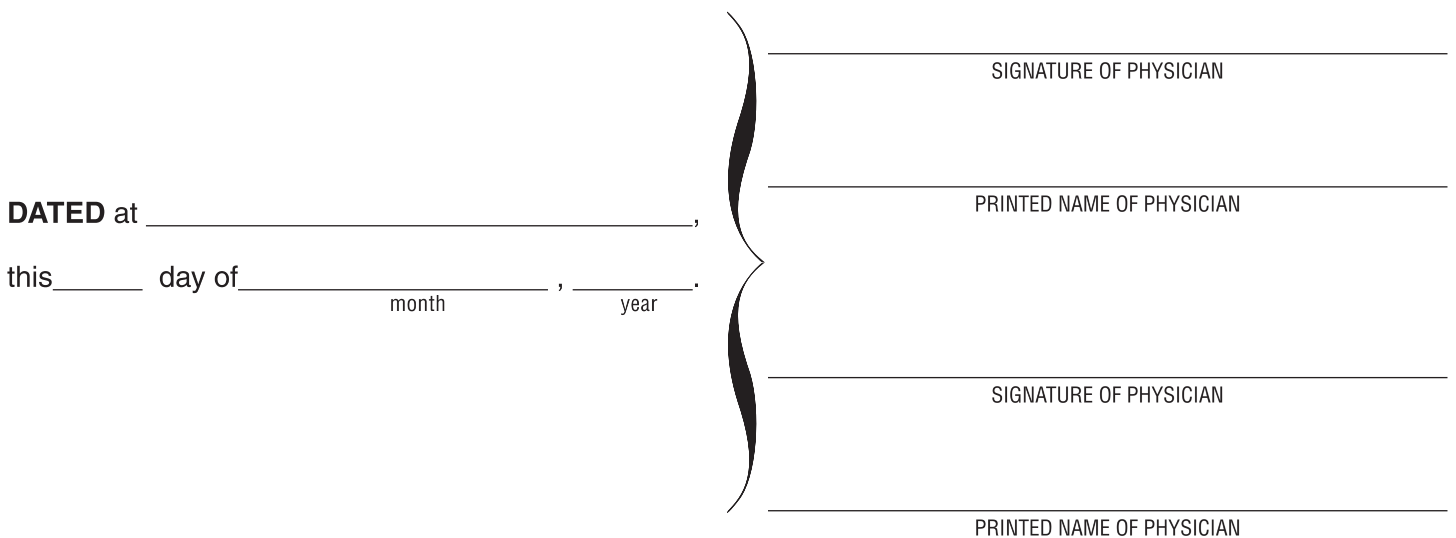
- ☐ The patient is apparently competent to consent to treatment and has been advised of the intention to transfer him/her, and of his/her right to participate in the review of the decision by the Capability and Consent Board.
- ☐ The patient is apparently incompetent to consent to treatment. The substitute decision-maker has been advised of the intention to transfer the patient to the above-named facility.

Copies of Form 7 (Certificate of Involuntary Admission) and Form 11 (Certificate of Renewal of Involuntary Admission) and treatment plans prepared with respect to the above-named patient are appended.



DATED at ___________________________________,

this______ day of____________________ , ________.
month year

SIGNATURE OF PHYSICIAN

PRINTED NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

PRINTED NAME OF PHYSICIAN

Information on this form is being collected pursuant to the *Mental Health Act* to provide notice to the Capability and Consent Board, Whitehorse General Hospital and Insured Health Services regarding an intention to transfer a patient. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse, Yukon Y1A 2C6, (867) 667-3010.