

**APPLICATION FOR TRANSFER  
OF A NON-RESIDENT  
INVOLUNTARY PATIENT**

**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 have completed Form 7 (Certificate of Involuntary Admission).

Copies must be provided to the:

- Chief Executive Officer, Whitehorse General Hospital; and
- Director of Insured Health Services.

**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 approve transfer of the patient, a resident of \_\_\_\_\_, to \_\_\_\_\_, a provincially approved facility located at \_\_\_\_\_, in the province of \_\_\_\_\_ on or about \_\_\_\_\_.  
Date (day/month/year)

I formed the opinion as to the need to transfer the patient to the above-named facility based on the following facts:

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- The patient is apparently competent to consent to treatment, and has been advised of the intention to transfer him/her.
- The patient is apparently not competent to consent to treatment and the substitute decision-maker has been advised of the intention to transfer him/her.

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

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

\_\_\_\_\_  
 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 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.