MENTAL HEALTH ACT, 2012
SEVENTH SCHEDULE
[Articles 17, 18(2)]

Mental Health Act	**This application is only valid for 120 hours from the date of the first medical recommendation and shall be submitted to the Commissioner** **CTO Ref No:**

APPLICATION
FOR A PERSON TO BE PLACED ON A COMMUNITY TREATMENT ORDER

To the Commissioner for the Promotion of Rights of Persons with Mental Disorders

Please grant/renew a Community Treatment Order for:

_____	_____	_____	_____	_M / F_
(Surname)	**(Name)**	**(ID No)**	**(D.O.B.)**	**(Sex)**

of (address) _____

_____

Is person detained in a mental health facility under an Involuntary Admission for Treatment Order?

- **□ NO**
- **□ YES IATO Ref No: _____**
- **□ YES EIATO Ref No: _____**
- **□ YES CDO Ref No: _____**

Is person already under a Community Treatment Order?

- **□ NO**
- **□ YES CTO Ref No: _____**

PART (A) – MEDICAL RECOMMENDATION BY RESPONSIBLE SPECIALIST

To be filled by responsible specialist in mental health	**I am a specialist in mental health and am the responsible specialist of the above named person. It is my opinion that the criteria for Community Treatment Order of the Mental Health Act apply to the person.** **I base my opinion on the following facts:** _____ _____ _____ _____ **Facts communicated to me by another person to support my opinion:** _____ _____ _____ _____
Attach care plan and Eighth Schedule if required	**□ The multidisciplinary care plan required in terms of the Mental Health Act is attached with this application.** **□ Key healthcare professional in terms of Article 18(3)(a) is** _____ **□ Eighth Schedule is enclosed (only if required)** _____ _____ _____ **(Name and Surname)** **(Signature)** **(Reg. No)** _____ _____ **(Date)** **(Time)**

PART (B) – MEDICAL RECOMMENDATION BY MEDICAL PRACTITIONER	
To be filled by medical practitioner	**I am a medical practitioner and have personally examined the above named person. It is my opinion that the criteria for a Community Treatment Order of the Mental Health Act apply to the person.** **I base my opinion on the following facts:** _____ _____ _____ _____ _____ **Facts communicated to me by another person to support my opinion:** _____ _____ _____ _____ _____ _____ _____ _____ **(Name and Surname) (Signature) (Reg. No)** _____ _____ **(Date) (Time)**
PART (C) – APPLICATION BY RESPONSIBLE CARER	
To be filled by responsible carer over the age of 18 years **Application is valid if Part [A], and, Part [B] have been filled**	**I _____ ID No _____ of** **(address)** _____ _____ **□ Request that _____ ID No _____ be placed on a Community Treatment Order.** **□ Do not request that _____ ID No _____ be placed on a Community Treatment Order.** **I am the responsible carer for the above person by virtue of being:** **□ a relative [state relationship] _____** **□ appointed by above person to be his/her responsible carer [submit evidence]** **□ others. I am his/her _____ [submit evidence]** _____ _____ _____ **(Signature) (Date) (Time)**

PART (D) – APPLICATION BY MENTAL WELFARE OFFICER	
To be filled by mental welfare officer if responsible carer does not agree that person needs a community treatment order or responsible carer is absent. **Application is valid if Part [A], and, Part [B] have been filled**	**I _____ ID No _____ am a mental welfare officer appointed by the Minister in terms of the Mental Health Act request that _____ ID No _____ be placed on a Community Treatment Order.** **I certify that** **□ the responsible carer has not agreed to such an Order** **□ the responsible carer cannot be found** **□ I have reviewed the above named person** **□ there are valid reasons for a Community Treatment Order** **OR** **I _____ ID No _____ am a mental welfare officer appointed by the Minister in terms of the Mental Health Act have reviewed _____ ID No _____ and in my opinion the named person does not need a Community Treatment Order because (specify)** _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ **(Signature) (Date) (Time)**
To be filled by Commissioner	**Application received on (date) _____ at (time) _____** **□ Care Plan submitted** **□ Key Healthcare Professional identified** **□ Medical Treatment is not to be provided by responsible specialist** **□ Medical Treatment is not to be provided by medical practitioner signing Part B of this Schedule** **□ Eighth Schedule submitted**

Comments

_____

_____

_____

_____

_____

_____

DECISION

□ Community Treatment Order granted/renewed for a period of _____ (months) and shall expire on (date) _____

□ Community Treatment Order not granted/renewed because:

_____

_____

_____

_____

_____

_____

My decision was communicated in writing to the:

□ Responsible Specialist on (date) _____

□ Medical Practitioner on (date) _____

□ Person and / or Responsible Carer on (date) _____

_____ _____ _____

(Signature) (Date) (Time)