Ontario

Ministry of Health

Form 3
Mental Health Act

Certificate of Involuntary Admission

Name of patient _____
(print name of patient)

Name of physician _____
(print name of physician)

Name of psychiatric facility _____
(name of psychiatric facility)

Date of examination _____
(date)

I hereby certify that the following three pieces of information are correct:

1. I personally examined the patient on the date set out above.
2. I am of the opinion that the patient named above is not suitable for voluntary or informal status.
3. Complete one or more boxes as appropriate.

☐ I am of the opinion that the patient named above meets the criteria set out in Box A. *(please complete Box A below)*

☐ I am of the opinion that the patient named above meets each of the criteria set out in Box B. *(please complete Box B below)*

Box A – Risk of Serious Harm

Note: Check one or more boxes as appropriate.

The patient is suffering from mental disorder of a nature or quality that likely will result in:

☐ serious bodily harm to the patient,

☐ serious bodily harm to another person

☐ serious physical impairment of the patient

unless he or she remains in the custody of a psychiatric facility.

Box B – Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet *all* of the following five criteria.

1. The patient has been found incapable, within the meaning of the *Health Care Consent Act, 1996* of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained.
2. The patient has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*

   ☐ serious bodily harm to the patient,

   ☐ serious bodily harm to another person,

   ☐ substantial mental or physical deterioration of the patient, or

   ☐ serious physical impairment of the patient;

(Disponible en version française)

See reverse.

Box B – Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria *(continued)*

3. The patient has shown clinical improvement as a result of the treatment.

4. The patient is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one.

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(please indicate one or more)*

   ☐ cause serious bodily harm to himself or herself, or

   ☐ cause serious bodily harm to another person, or

   ☐ suffer substantial mental or physical deterioration, or

   ☐ suffer serious physical impairment

_____ _____

(Date of signature) (signature of attending physician)

Notes

1) This certificate is valid for *14 calendar days*, including the day upon which it was signed.

2) The following actions must be taken promptly after this form is signed:

   a) The signing physician must give the patient a properly executed Form 30 notice and notify a rights adviser.

   b) The rights adviser must meet with the patient and explain to him or her the significance of the certificate and the right to have it reviewed by the Consent and Capacity Board.

(Disponible en version française)

