**Form H6** *Regulation 14(1)(a) and (b)* **Mental Health Act 1983**

**Section 21B – authority for detention after absence without leave for more than 28 days**

**PART 1**

*(To be completed by the responsible clinician)*

To the managers of (*name and address of hospital in which the patient is liable to be detained*)

|  |
| --- |
|  |

I examined *(PRINT full name of patient)*

|  |
| --- |
|  |

on

|  |
| --- |
|  |

(*date of examination*)

who:

1. was absent without leave from hospital or the place where the patient ought to have

been beginning on

|  |
| --- |
|  |

(*date absence without leave began)*

1. was / is**\***

liable to be detained for a period ending on (\**delete the phrase which does*

*not apply*)

|  |
| --- |
|  |

*(date authority for detention would have expired, apart from any extension under section 21, or date on which it will expire)*

and

(c) returned to the hospital or place on

|  |
| --- |
|   |

*(date)*

I have consulted (*PRINT full name of approved mental health professional*)

|  |
| --- |
|  |

who is an approved mental health professional.

I have also consulted (*PRINT* *full name and profession of person consulted*)

|  |
| --- |
|  |

who has been professionally concerned with the patient’s treatment.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary

(i) for the patient’s own health

(ii) for the patient’s own safety

(iii) for the protection of other persons

(*delete the indents not applicable*)

that this patient should receive treatment in hospital,

because *– (Your reasons should cover both (a) and (b) above. As part of them: describe the patient’s symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate*.)

|  |
| --- |
|  |

|  |
| --- |
| *(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)* |

Such treatment cannot be provided unless the patient continues to be detained under the Act, for the following reasons – *(Reasons should indicate why informal admission is not appropriate.)*

|  |
| --- |
|  |

|  |
| --- |
| *(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)* |

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.

The authority for the detention of the patient is / is not**\*** due to expire within a period of two months

beginning with the date on which this report is to be furnished to the hospital managers. (\**Delete the phrase which does not apply*)

*Complete the following only if the authority for detention is due to expire within that period of two months.*

This report shall / shall not**\*** have effect as a report duly furnished under section 20(3) for the

renewal of the authority for the detention of the patient. (\**Delete the phrase which does not apply*).

*Complete the following in all cases.*

I am furnishing this report by:

(*Delete the phrase which does not apply)*

today consigning it to the hospital managers’ internal mail system.

today sending it to the hospital managers, or a person authorised by them to receive it, by means of electronic communication.

sending or delivering it without using the hospital managers’ internal mail system.

Signed

|  |
| --- |
|  |

PRINT NAME Date

|  |  |
| --- | --- |
|  |  |

**PART 2**

*(To be completed on behalf of the hospital managers)*

This report was (*Delete the phrase which does not apply*)

furnished to the hospital managers through their internal mail system

furnished to the hospital managers, or a person authorised by them to receive it, by means of electronic communication.

received by me on behalf of the hospital managers on

|  |
| --- |
|  |

*(date)*

Signed

|  |
| --- |
|  |

on behalf of the hospital managers

PRINT NAME Date

|  |  |
| --- | --- |
|  |  |