Supervised Community Care - Amendments to Care Plan - Appointments and Community-based Services - *Mental Health Act*, Part II.I

A copy of the amendments to care plan must be sent to Psychiatric Patient Advocate Services.
Fax Number: (506) 462-2230.

Name: ____________________ Medicare Number: ____________________

Address: ____

Phone number: ____________________ DOB (MM/DD/YYYY): ______/______/__________

I, Dr.____________________ *(Name of Psychiatrist)* am the issuing psychiatrist of ____________________ *(Name of Individual)*. It is of my opinion that the following amendments be made to this individuals Supervised Community Care plan effective on ____________________ (date).

Attending appointments/community-based services

The following is required:

Appointments/ Community-based Services	Service Location	Frequency

Additional comments:

____

____
(Signature of Individual/Substitute Decision Maker, if Applicable)

____
(Date)

____
(Signature of Treating Psychiatrist)

____
(Date)

____
(Phone Number)