

Supervised Community Care - Renewal Form

Mental Health Act, Part II.I



A copy of the Supervised Community Care Renewal Form is to be sent to Psychiatric Patient Advocate Services. Fax Number: (506) 462-2230.

Name: _____

Address: _____

Phone number: _____ DOB (MM/DD/YYYY): ____/____/____

I, Dr. _____ (Full Name), have personally examined _____ (Name of Individual) at _____ (Location of Examination). I am of the opinion that the individual named above continues to meet the criteria of a Supervised Community Care plan:

- the person has a serious mental illness, and
- the mental illness is continuous in nature, and
- the person's mental illness causes severe limitations in social community functioning.

I am of the opinion that the Supervised Community Care plan has demonstrated efficiency, and I therefore apply for the renewal of the Supervised Community Care plan for the duration of one year, unless it is renewed or cancelled earlier.

(PSYCHIATRIST'S NOTES)

Notes: 34.08(1) The review board may renew the supervised community care plan after a hearing to review the plan under subsection 34.1(3).

(Signature of Individual or Substitute Decision-maker, if Applicable)

(Date)

(Signature of Treating Psychiatrist)

(Date)