**Notice requiring patient to undergo a 5 day further period**

**of assessment and treatment**

|  |  |
| --- | --- |
|  | *Name of patient* |
| To: | Click or tap here to enter text. |
|  | *Date of birth* |
| Patient's date of birth: | Click or tap here to enter text. |
|  | *Address* |
| Of: | Click or tap here to enter text. |
|  |
| **You are required to undergo a 5 day further period of assessment and treatment** |
|  | *Name of responsible clinician conducting assessment and treatment* |
| to be conducted by: | Click or tap here to enter text. |
|  | *Date assessment and treatment to commence* |
| beginning on: | Click or tap to enter a date. |
|  | *Date assessment and treatment period to terminate* |
| and ending on: | Click or tap to enter a date. |

**You are required to attend:**

|  |  |  |  |
| --- | --- | --- | --- |
|  \*(i) |  | As an outpatient at: |  |
|  |  | *Address where assessment and treatment to take place, date(s) and reporting time(s)* |  |
|  |  | Click or tap here to enter text. |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |

*\*Delete one or*

|  |  |  |  |
| --- | --- | --- | --- |
|  \*(ii) |  | As an inpatient to be detained in the hospital specified below |  |
|  |  | *Name and address of hospital where assessment and treatment to take place* |  |
|  |  | Click or tap here to enter text. |  |
|  |  |  |
|  |  |  |
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|  |  |  |
| --- | --- | --- |
|  |  Click or tap to enter a date. |  |
|  | *Signature of mental health practitioner Date* |  |