



**Declaration**

Mark  applicable box

doctor  authorised mental health practitioner

I have examined the person within 3 days preceding this recommendation; and I am satisfied that the assessment criteria apply to the person.

Doctor / authorised mental health practitioner

Signature	Print name
	Date <input type="text"/> / <input type="text"/> / <input type="text"/>

Business address

Town/suburb  State  Postcode

Phone No.

**To: administrator, authorised mental health service**

**MUST BE completed by health service employee when assessment period starts**

**Start of assessment period**

Mark  if applicable

Person brought to health service by ambulance

Name of health service

Start date  /  /  Start time :  24 hour

Health service employee

Signature	Print name
	Designation