EXTENDED LEAVE REVIEW PANEL HEARING DIRECTIVE

Fax to: Review Board 604-660-2403

Client's Name: ____ Date of Birth: ___________________

Facility's Name: ____

You have been on extended leave for 12 or more consecutive months and no Review Panel hearing has been held during this time. **The *Mental Health Act* requires that your file be reviewed at this time to determine if a hearing by the Mental Health Review Board should be held in regards to whether you should be decertified.**

If you would like to request a hearing at this time, please indicate so below. If you do not wish a hearing at this time and wish to waive your right to have your file reviewed, please indicate so below.

_____ I do not wish a Hearing at this time and waive my rights to have my file reviewed.

_____ I wish a Hearing before the Mental Health Review Board. (Form 7 must be completed and faxed to the Board office.)

_____ I would like to have my file reviewed.

____ _____________________________________

Client's Signature Date

Yes _____ I have received and signed a Form 13 (Notification to Involuntary Patient of Rights under the *Mental Health Act*)

If you have any questions, please consult with your clinician, phone the Mental Health Review Board at 604-660-2325, or the Mental Health Law Program at 604-685-3425 or toll free 1-888-685-6222.

- -

CASEWORKER/CLINICIAN (<u>only</u> if patient is not able to sign above):

Reason client is unable to sign:

I certify that I have discussed with the patient his/her option of requesting a hearing before the Mental Health Review Board at this time and I have indicated his/her wishes above. The patient has received a form 13 as required under the Mental Health Act.

____ _____________________________________

Signature Date

____

Print name and title

FOR OFFICE USE	
Original Certification Date	
Discharge Date	
Expiration Date	

Mental Health Review Board
#1270 – 960 Robson St.
Vancouver, BC V6B 5J3

Telephone: (604) 660-2325
Facsimile: (604) 660-2403
www.bcmhrb.ca