BRITISH COLUMBIA
The Best Place on Earth

EXTENDED LEAVE REVIEW PANEL HEARING DIRECTIVE

Fax to: Mental Health Review Board @ 604-660-2403
Email to: MHRBScheduling@gov.bc.ca

Client's Name:_____ Date of Birth: _____

PHN Number:_____ Date released on leave:_____

Designated Facility:_____ Date of Last Review Panel Hearing:_____

Current Mental Health Team/Site/Facility:_____

You have been on extended leave for 12 or more consecutive months and no Review Panel hearing has been held or requested 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 do not wish a hearing at this time and wish to waive your right to have your file reviewed, please indicate so below. If you would like to request a hearing at this time, please indicate so below and complete and include a Form 7. If you would like to proceed with having your file reviewed, please indicate that selection below. If you do not make a selection, your file will be reviewed as required by the *Mental Health Act*.

Please select **ONE** option only:

_____ 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

I have received and signed a Form 13 (Notification to Involuntary Patient of Rights under the *Mental Health Act*). Please check one: Yes ☐ No ☐

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.

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CASEWORKER/CLINICIAN (<u>only</u> if patient has not signed above):

Reason client has not signed: _____

I certify that I have discussed with the client their option of requesting a hearing before the Mental Health Review Board at this time and I have indicated their wishes above OR the client was unwilling or unable to select an option. The client has received a form 13 as required under the Mental Health Act.

_____ _____
Signature Date

_____
Print name and title

Mental Health Review Board
#1270 – 605 Robson Street
Vancouver, BC
V6B 5J3

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