

# Notification to the Mental Health Commission of the discharge of a child from an adult unit in an approved centre



## Clinical Practice Form

### Instructions

The following form is to be used:

To notify the discharge of a child from an approved centre for adults

Please write clearly in the boxes in **BLOCK CAPITALS** in **BLACK** ink

Patient Details	
1. Surname:	
2. First Name(s):	
3. DOB:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)
4. Age (on date of admission)	<input type="text"/> <input type="text"/> years of age (if the child was <b>15 years of age or under</b> on the date of admission please <b>complete question 11</b> )
5. Date of Admission:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)

I confirm that the above mentioned child was discharged from

6. Approved Centre:		
7. Ward/Unit:		
8. On the following date:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)	
9. Legal Status on the day of discharge:	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary
10. Type of Discharge:	<input type="checkbox"/> Discharged from this approved centre	<input type="checkbox"/> Discharged from this approved centre and admitted to another approved centre (if yes please specify name of approved centre)
11. Were attempts made to discharge this child to an age appropriate centre during their admission?	<input type="checkbox"/> Yes (if yes, please provide brief details below)	<input type="checkbox"/> No
12. Signed:		
13. Print name:		
14. Job Title:		
15. Date:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)	

This form should be completed and faxed to:  
 Standards and Quality Assurance Division  
 Mental Health Commission  
 Tel: 00353 1 636 2401/02 Fax: 00 353 1 636 2440