Coimisiún Meabhair-Shláinte | Mental Health Commission

# NOTICE OF PATIENT TRANSFER TO ANOTHER APPROVED CENTRE

(OTHER THAN THE CENTRAL MENTAL HOSPITAL)

Revised July 2019

**FORM 10**

Mental Health Acts 2001 to 2018

**Section 20 OR 21**

**PLEASE COMPLETE IN BLOCK CAPITALS**

**1. Full name of patient being transferred**

**2. Date of birth OR age** (if date of birth not known) ☐☐/☐☐/☐☐☐☐ **Age:** _____ **Gender:** M ☐ F ☐

**3. Name and address of Approved Centre to which patient was first admitted**

**4. Date of admission** ☐☐/☐☐/☐☐☐☐

## TRANSFER DETAILS

**The patient is being transferred from:**

**5. Approved Centre from which the patient is being transferred** (if other than Section 3 above)

**The patient is being transferred to:**

**6. Approved Centre to which the patient is being transferred**

**7. Transfer made pursuant to:** Section 20 ☐ OR Section 21 ☐

**The following are the reasons for the transfer:**

**8. Give reasons for transfer by reference to Section 20 OR Section 21**

**9.** The Clinical Director of the Approved Centre to where the patient is being transferred has agreed to this transfer.

**10. Date of transfer:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

**11.** I hereby authorise the transfer of the patient.

**12.** I shall give notice of this transfer to the patient and I shall give notice to the Commission.

**Signed:** _____ **(Clinical Director)**

**Print name:** _____ **(Clinical Director)**

**MCRN:** ☐☐☐☐☐☐

**Date:** ☐☐/☐☐/☐☐☐☐ **Time:** (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

For use only in accordance with the Mental Health Acts 2001 to 2018. Penalties apply for giving false or misleading information.
**NOTE:** For information in relation to the legislation, please refer to **www.mhcirl.ie/legislation**.
For information in relation to the Sections of the Mental Health Act 2001 to which this form refers, please click **here**.