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PERT / Psychiatric Patient Assessment Form
Emergency Department

To be completed for every ED patient before TOC to PERT / Psychiatry

	Item	Check
1.	**Vital Signs (temp, pulse, RR, B/P, O−Sat plus Finger Glucose in altered patient):**	
	• Vital signs are normal / at baseline	☐
	• Vital signs are abnormal but appropriate for patient condition (appropriate testing that is clinically indicated has been completed). **Nursing staff to continue to monitor Vital Signs. If they worsen or do not improve, inform MRP.**	☐
2.	**High Risk features have been reviewed and addressed as clinically indicated:**	
	• Acute / New onset	☐
	• Visual Hallucinations	☐
	• Inability to complete a reasonable history	☐
	• History suggestive of life−threatening ingestion / overdose	☐
	• First incidence of psychiatrically altered patient, especially over 55 years of age	☐
	• Medications reviewed especially for new medications	☐
	• Altered sensorium, especially fluctuation of delirium, unexplained	☐
	• Seizure, including tongue biting	☐
	• Recent trauma	☐
	• Concern for infection (including IVDU)	☐
	• Abnormal focused examinations	☐
	• Immunodeficiency	☐
3.	**Investigations ordered have been reviewed:**	
	• Yes	☐
	• Some are pending (non−critical) and I will follow up on them	☐
4.	**Interim orders for regular medications, NRT, chemical restraints etc. completed**	
	• Yes	☐
5.	**This patient is:**	
	• SCS: Stable for transfer to PERT	☐
	• NFS, WS: Stable for PERT / Psychiatrist assessment	☐

Comments from ED Physician:

Rev. 11/2022(v1)

NOTES:

- Initial Emergency Medicine assessment is not intended to rule out every concomitant medical condition. If the patient situation changes, please inform MRP.
- The psychiatrist is encouraged to consult any appropriate service (Emergency Medicine included) if clinically indicated at any time in the journey of the patient.

Dr.

Emergency Physician Name / Signature

01/May/2023 12:25

Date / Time
(dd/mm/yyyy hh:mm)

ASSMT103

Chart Copy − Do Not Destroy

Ministry of Health

Ontario

Form 1

Mental Health Act

Application by Physician for Psychiatric Assessment

This auto-populated version of the Form 1 and 42 is only to be used within psychiatric facilities where the Form 42 will be immediately issued to the recipient by the same physician that is completing the Form 1.
Please note that there is a print button at the end of the form. This form will only print once all mandatory fields are completed.

Clear Form

Name of physician * Dr.
(print name of physician)

Please Select Site

Physician address * Niagara Health, 1200 Fourth Ave, St Catharines, ON, L2S 0A9 - St Catharines Site (SCS)
(address of physician)

Telephone number * (905) 3784647

Fax number ( )

On * 31/Jan/2023
(date)

I personally examined *
(print full name of person)

whose address is *
(home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days. In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act Serious Harm Test

The Past / Present Test * *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations: *

Facts communicated to me by others:

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

(Disponible en version française)

See reverse

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations: *

_____

_____

_____

Facts communicated by others:

_____

_____

_____

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*

   ☐ serious bodily harm to himself or herself,

   ☐ serious bodily harm to another person,

   ☐ substantial mental or physical deterioration of himself or herself, or

   ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996,* of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*

- ☐ cause serious bodily harm to himself or herself, or
- ☐ cause serious bodily harm to another person, or
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

_____

_____

_____

Facts communicated by others:

_____

_____

_____

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date * 31/Jan/2023 Today's time * _____

Examining physician's signature _____
(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

31/Jan/2023
(Date and time detention commences)

_____
(signature of physician)

31/Jan/2023
(Date and time Form 42 delivered)

_____
(signature of physician)

(Disponible en version française)

Ministry of Health

Ontario

Form 42

Mental Health Act

Notice to Person under Subsection 38.1 of the Act of Application for Psychiatric Assessment under Section 15 or an Order under Section 32 of the Act

Part I *(complete only if appropriate)*

To: _____
(name of person)

of _____
(home address)

This is to inform you that Dr. _____
(name of physician)

examined you on 31/Jan/2023 and has made an application for you to
(date of examination) (day / month / year)

have a psychiatric assessment.

Part A and/or Part B must be completed

Part A

That physician has certified that he/she has reasonable cause to believe that you have:

Check Box(es)

- ☐ threatened or attempted or are threatening or attempting to cause bodily harm to yourself;
- ☐ behaved or are behaving violently towards another person or have caused or are causing another person to fear bodily harm from you; or
- ☐ shown or are showing a lack of competence to care for yourself.

and that you are suffering from a mental disorder of a nature or quality that likely will result in:

Check Box(es)

- ☐ serious bodily harm to yourself;
- ☐ serious bodily harm to another person; or
- ☐ serious physical impairment of you.

Part B

That physician has certified that he/she has reasonable cause to believe that you:

a) have previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in

- ☐ serious bodily harm to yourself,
- ☐ serious bodily harm to another person,
- ☐ substantial mental or physical deterioration of you, or
- ☐ serious physical impairment of you;

b) have shown clinical improvement as a result of the treatment;

c) are suffering from the same mental disorder as the one for which you previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

See reverse

Part B *(continued)*

d) given your history of mental disorder and current mental or physical condition, you are likely to

- ☐ cause serious bodily harm to yourself,
- ☐ cause serious bodily harm to another person,
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment;

e) have been found incapable, within the meaning of the Health Care Consent Act, 1996 of consenting to your treatment in a psychiatric facility and the consent of your substitute decision-maker has been obtained; and

f) you are not suitable for admission or continuation as an informal or voluntary patient.

The application is sufficient authority to hold you in custody in this hospital for up to 72 hours.

You have the right to retain and instruct a lawyer without delay.

31/Jan/2023 _____
(date) (signature of attending physician)

Part II *(complete only if appropriate)*

To: _____
(name of person)

of _____
(home address)

This is to inform you that _____
(name of Minister of Health and Long-Term Care)

Minister of Health and Long-Term Care for the Province of Ontario, has reasonable cause to believe that you are suffering from mental disorder of a nature or quality that likely will result in:

Check Box(es)

- ☐ serious bodily harm to yourself; or
- ☐ serious bodily harm to another person.

unless you are placed in the custody of a psychiatric facility and has by Order dated

_____ , authorized your custody in a psychiatric facility for up to 72 hours.
(date of order) (day / month / year)

You have the right to retain and instruct a lawyer without delay.

_____ _____
(date) (signature of attending physician)

Please remember to sign page 3 of the Form 1 (3 signatures required) and page 2 of the Form 42 (1 signature required).

Print Form

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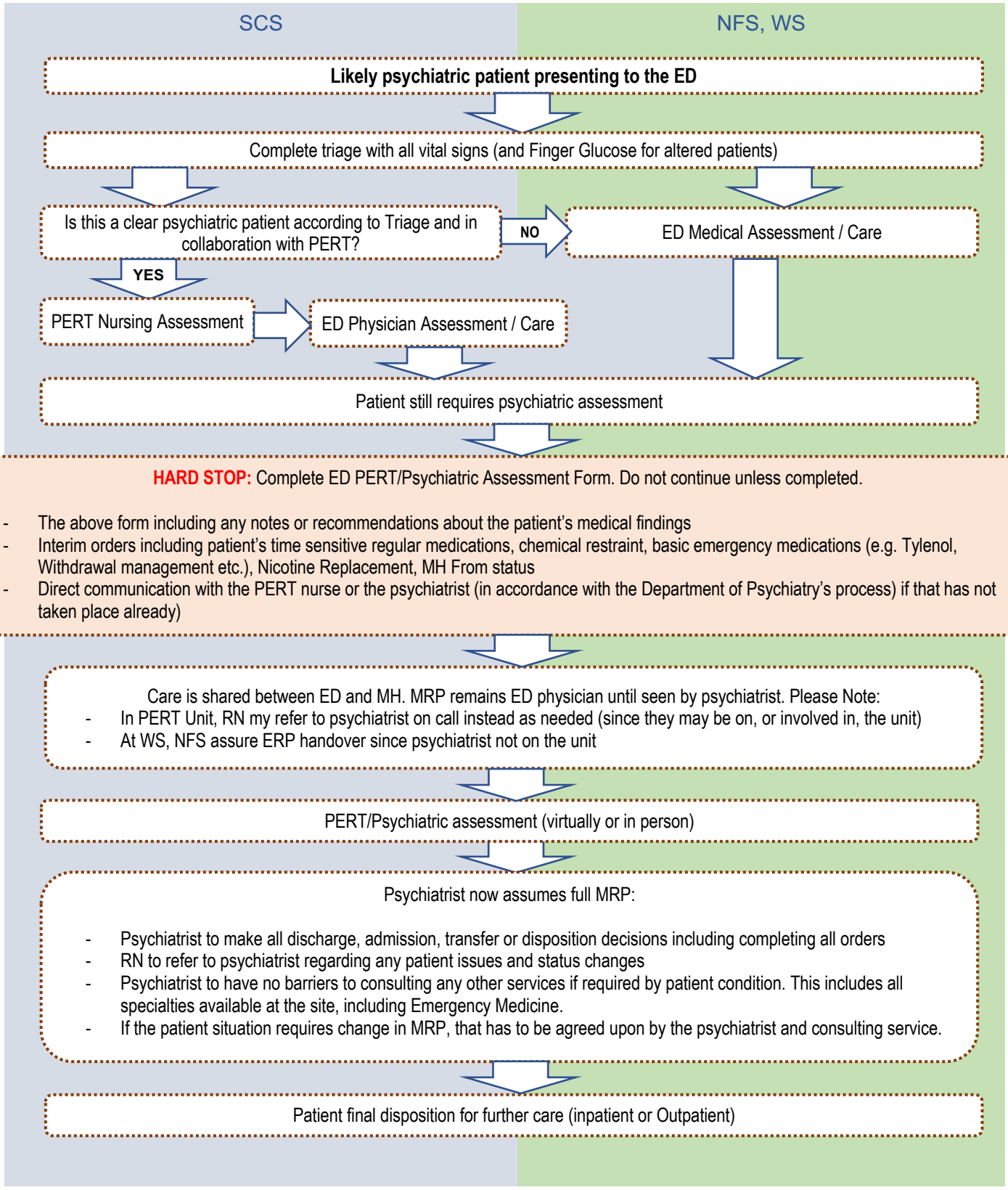
Emergency Department PERT/Psychiatric Patient Assessment Form

Place Patient Sticker Here

Psychiatric patient journey flowchart in both ED and PERT by ED site:



Recommended study material online: Podcast~ bit.ly/edclear1 Publication~ bit.ly/edclear2