Ministry of Health

Ontario

Form 45
Mental Health Act

Community Treatment Order

Part 1 – To be Filled Out by Examining Physician

Name of person _____
(print name of patient)

Name of physician _____
(print name of physician)

Name of substitute decision-maker *(if applicable)* _____
(print name of substitute decision-maker)

Name of psychiatric facility *(if applicable)* _____
(name of psychiatric facility)

Date of examination _____
(date)

This community treatment order for the above named person is the:

☐ first for this person ☐ _____ renewal
(no. of times CTO has been renewed)

Date of issue of previous community treatment order *(if applicable)* _____
(date)

Date of expiry of previous community treatment order *(if applicable)* _____
(date)

During the previous three year period, the person named above:

☐ has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three year period, OR

☐ has been the subject of a previous community treatment order.

Criteria for Community Treatment Order

(Note: All the criteria set out below must be met for this order to be valid)

I am of the opinion that

a) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community, AND

b) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, 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 deterioration of the person, OR
- ☐ suffer substantial physical deterioration of the person OR
- ☐ suffer serious physical impairment of the person,

AND

c) the person is able to comply with the community treatment plan contained in the community treatment order, AND

(Disponible en version française)

See reverse

d) the treatment or care and supervision required under the terms of the community treatment order are available in the community, AND

e) If the person is not currently a patient in a psychiatric facility, the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15(1) or (1.1).

The facts on which I formed the above opinion are as follows:

Rights Advice

Note: The person and his or her substitute decision–maker, if applicable, must receive rights advice before the order is issued.

I am satisfied that the substitute decision-maker of the person, if applicable, has consulted with a rights adviser and been advised of his or her legal rights, AND

I am satisfied that the person:

☐ has consulted with a rights adviser and been advised of his or her legal rights, or

☐ has not consulted with a rights adviser because he or she has refused to consult a rights adviser.

Community Treatment Plan

Note: A copy of the community treatment plan must be attached to this order.

I am satisfied that a community treatment plan has been devised for the person.

I have consulted with all the persons named in the community treatment plan.

I am satisfied that:

☐ the person OR

☐ the person's substitute decision-maker, if the person is incapable, consents to the community treatment plan.

The community treatment plan for the person is

(Describe the community treatment plan. Use back of this form if necessary. The community treatment plan must be attached to this order.)

(Disponible en version française)

Part 2 – To be Filled Out by the Person or the Person's Substitute Decision-Maker

Undertaking of Person or Person's Substitute Decision-Maker
(to be completed by the person or the person's substitute decision maker, if applicable)

I am

☐ the person named above. I promise to comply with all my obligations as set out in the community treatment plan, OR

☐ the person's substitute decision-maker. I promise to use my best efforts to ensure that the person named above complies with all the obligations as set out in the community treatment plan.

By my signature at the bottom of this order, I signify that I consent to the community treatment plan, and I consent to, and am assuming my undertakings as stated in, the community treatment plan.

Part 3 – Time in Force – To be Completed by the Examining Physician

This community treatment order is in force for 6 months, including the day upon which it is signed, and expires at midnight on the _____ unless it is terminated at an earlier date.
(date) (day / month / year)

Part 4 – Patient Right to Apply to Consent and Capacity Board

A person who is subject to a community treatment order, or any person on his or her behalf, may apply to the Board using a ***Form 48*** to inquire into whether or not the criteria for issuing or renewing this community treatment order have been met.

Signed at _____
(name of psychiatric facility, or name of place [eg. doctor's office, hospital] where community treatment order signed)

_____ _____
(Date) (signature of physician)

_____ _____
(signature of person) (signature of substitute decision-maker) *(if applicable)*

Notes:

The following actions must be taken by the physician who signs this order immediately after the order is signed:

1. A copy of this order, including the community treatment plan must be given to:
   a) the person,
   b) the person's substitute decision-maker, if applicable,
   c) the officer in charge of a psychiatric facility, if applicable,
   d) any other health practitioner or other person named in the community treatment plan.
2. A notice in the approved form ***(Form 46)*** must be given to the person that he or she is entitled to a hearing before the Consent and Capacity Board.