Ontario

Ministry of Health
and Long-Term Care

# Application to the Board for an Involuntary Patient's Transfer to Another Psychiatric Facility under Section 39(8) of the Act

**Form 52**

*Mental Health Act*

*Consent and Capacity Board*

**Part I This section must be completed by all applicants**

I, _____
(print full name of applicant)

apply to the Board for a hearing to determine whether or not _____
(print full name of patient)

who is a patient at _____
(name of current psychiatric facility)

should be transferred to _____
(name of proposed receiving psychiatric facility)

I am or I represent:

☐ the Officer in Charge of the patient's current psychiatric facility,

*or*

☐ the Minister of Health and Long-Term Care,

*or*

☐ the Deputy Minister of Health and Long-Term Care.

_____ _____
(date) (signature of applicant)

**Part II This information is not required but will assist us in scheduling the hearing**
(provide only information where known)

1. If you are or you represent the Officer in Charge of the patient's current psychiatric facility, provide the name, telephone and fax numbers of a hospital official who may assist in arranging the hearing and of your lawyer or agent (if any).

_____ ( ) _____ ( ) _____
(name of hospital official) (telephone no.) (fax no.)

_____ ( ) _____ ( ) _____
(name of lawyer or agent) (telephone no.) (fax no.)

2. If you are or you represent the Minister of Health and Long-Term Care or the Deputy Minister of Health and Long-Term Care, provide an address and telephone number where you may be contacted by the Board.

_____ ( ) _____
(address) (telephone no.)

Name, telephone and fax numbers of your lawyer or agent (if any).

_____ ( ) _____ ( ) _____
(name of lawyer or agent) (telephone no.) (fax no.)

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3. Name, telephone and fax numbers of the Officer in Charge of the proposed receiving psychiatric facility named in your application.

| (name of the Officer in Charge of the proposed receiving psychiatric facility) | ( ) (telephone no.) | ( ) (fax no.) |
|---|---|---|

4. Name, telephone and fax numbers of a lawyer or agent for the patient (if any):

| (name of lawyer or agent) | ( ) (telephone no.) | ( ) (fax no.) |
|---|---|---|

The following actions must be taken promptly after this form is signed:

1. The officer in charge must give the patient a copy of this form and notify a rights adviser.
2. The rights adviser must meet with the patient and explain to him or her the significance of the application.

Fax completed form to the Board at 1 866 777–7273 or send by email to: ccb@ontario.ca.

Provide a copy of this form to the patient.

For assistance, call: 1 866 777 7391
TTY/TDD: 1 877 301–0TTY(0889).