Form CTO5 *Regulation 6(8)(a) and (b)* **Mental Health Act 1983**

Section 17F(4) – revocation of community treatment order

(Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional)

PART 1

I (*PRINT full name, address and, if sending by means of electronic communication, email address of the responsible clinician*)

am the responsible clinician for

(PRINT full name and address of community patient)

who is detained in

(name and address of hospital)

having been recalled to hospital under section 17E(1) of the Act.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary for

(i) the patient's own health

(ii) the patient's own safety

(iii) the protection of other persons

(delete the indents not applicable)

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained for medical treatment under the Act,

Form amended by SI 2020/1072 for use from 1 December 2020

because – *(Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.)*

(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)

I am also of the opinion that taking into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient at the hospital named above.

Signed	Date
	/ /

Responsible clinician

PART 2

I (*PRINT full name, address and, if sending by means of electronic communication, email address*)

am acting on behalf of,

(name of local social services authority)

and am approved to act as an approved mental health professional for the purposes of the Act by *(delete as appropriate)*

that authority

(name of local social services authority that approved you, if different).

I agree that:

(i) the patient meets the criteria for detention in hospital set out above and

(ii) it is appropriate to revoke the community treatment order.

Signed | Date

/ /

Approved mental health professional

PART 3

I exercise my power under section 17F(4) to revoke the community treatment order in respect of the patient named in Part 1 who has been detained in hospital since

: (*time*) on / / (*date*)

having been recalled under section 17E(1).

Signed | Date

/ /

Responsible clinician

THIS REVOCATION ORDER IS NOT VALID UNLESS ALL THREE PARTS ARE COMPLETED AND SIGNED. IT MUST BE SENT AS SOON AS PRACTICABLE TO THE MANAGERS OF THE HOSPITAL IN WHICH THE PATIENT IS DETAINED