

Form 8
Certificate of Cancellation of Leave
(Section 44 - *Involuntary Psychiatric Treatment Act*)

I, Dr. _____ (*full name*), a psychiatrist on the staff of

_____ (*name of psychiatric facility*), am the psychiatrist for

_____ (*full name of patient*), an involuntary patient who is
currently living outside of the psychiatric facility on a certificate of leave.

I am cancelling the patient's certificate of leave dated _____ effective the date of this
Certificate of Cancellation of Leave because I have knowledge that: (*check all that apply*)

- the patient has breached a condition of his/her certificate of leave
- the patient's condition may present a danger to the patient or others
- the patient has failed to report as required by their certificate of leave

(*date of signature*) (*dd/mm/yyyy*)

(*signature of psychiatrist*)

(*psychiatrist's name - printed*)

Note:

This form authorizes a peace officer for up to 30 days after the date it is signed to take the patient into custody and to a psychiatric facility for an involuntary psychiatric assessment.