Form HO 2

Regulation 4(1)(a)(ii)

Mental Health Act 1983 section 2 - application by approved mental health professional for admission for assessment

To the managers of

(name and address of hospital)

(full name) I

(full address) of

apply for the admission of

(full name of patient)

(full address of patient) of

for assessment in accordance with Part 2 of the Mental Health Act 1983.

I am acting on behalf of

(name of local social services authority)

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

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

The following section should be completed if nearest relative is known

Complete (a) or (b) as applicable and delete the other

(a) To the best of my knowledge and belief

(full name and address)

Please turn over

is the patient's nearest relative within the meaning of the Act.

OR

(b) I understand that

(full name and address)

has been authorised by a county court/the patient's nearest relative* to exercise the functions under the Act of the patient's nearest relative.

(delete as appropriate)*

I have/have not yet* informed that person that this application is to be made and of the nearest relative's power to order the discharge of the patient.

The following section should be completed if the nearest relative is not known

Delete (a) or (b)

(a) I have been unable to ascertain who the patient's nearest relative is within the meaning of the Act.

OR

(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.

The remainder of the form must be completed in all cases

(date)

I last saw the patient on ______ which was within the period of 14 days ending on the day this application is signed.

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient.

Form HO 2 (Cont'd)

(insert reasons)

Signed: ……………………………………………………………………………………

Date: ……………………………………………………………………………………