

Review of Prohibitions and Restrictions on the use of telephones

Instructions

The following form is to be used:

where the patient's RMO has restricted or prohibited the patient's use of a telephone under section 284 of the Act, and the specified person (the patient) has requested a review of that restriction or prohibition.

Where not completing this form electronically, to ensure accuracy of information, please observe the following conventions:

Write clearly within the boxes in
BLOCK CAPITALS
and in BLACK or BLUE ink

For example

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Shade circles like this ->

Not like this ->



Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number

--	--	--	--	--	--	--	--	--	--	--	--

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name (s)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Other / Known As

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title

--	--	--	--	--	--	--	--	--	--	--

Gender

- Male
- Female
- Prefers not to say
- Not listed

DoB

--	--	--	--

 /

--	--	--	--

 /

--	--	--	--	--	--

If not listed, please specify

--	--	--	--	--	--

I confirm that the patient is detained under the care of:

Hospital

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Ward / Clinic

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

RMO Details

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Title

--	--	--	--	--	--	--	--	--	--	--

Hospital

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Ward / Clinic (If appropriate)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Telephone No.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

e-mail address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Approved under section 22 of the Act by:

Health Board **NHS**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--



Review Details

The restriction or prohibition was made on: Date [][] / [][] / [][][][]

The specified person (patient) requested a review on: Date [][] / [][] / [][][][]

The restriction or prohibition was reviewed on: Date [][] / [][] / [][][][]

The outcome of the review was:
○ the prohibition or restriction should remain in place
○ the prohibition or restriction should be discontinued

for the following reasons:

1 [Large empty box for reasons]

Notifications

Regulations require that:

the specified person (the patient);
the patient's named person; and
the Mental Welfare Commission

be informed of outcome of the review

Completed by:

Surname [Grid]

First Name [Grid]

Job Title [Grid]

Signature [Signature box]

Date [][] / [][] / [][][][]

