



**Queensland
 Government**

Mental Health Act 2016

**Limited Community Treatment
 (LCT) Access and Return**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

• This form is to be completed for each occasion of limited community treatment accessed by the patient.

TYPE OF LEAVE		
AUTHORISATION DATE		
OUT / DUE BACK	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
RETURNED	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
OUT / DUE BACK	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
RETURNED	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
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	Date:	Time (24 hr):
	Health service employee name:	Signature:
RETURNED	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
OUT / DUE BACK	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:
RETURNED	Date:	Time (24 hr):
	Date:	Time (24 hr):
	Health service employee name:	Signature:

Attach additional pages if required.

DO NOT WRITE IN THIS BINDING MARGIN

LIMITED COMMUNITY TREATMENT (LCT) ACCESS AND RETURN





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