NSW GOVERNMENT Health

Facility:

NSW HEALTH/ NSW POLICE MOU ABSCONDED PATIENT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REPORT TO POLICE (PART A)

Telephone Contact With Police Must Be Made Prior To Forwarding This Form

Health staff must also complete Absconded Patient Outcome Report to Police (Part B) to advise Police of the outcome

Additional Patient Information

Preferred Name | Phone Number | Recent Photo Attached ☐ Yes ☐ No

Cultural and Religious Considerations

Preferred Language:

Patient Description *(Tick appropriate option)*

Build		☐ Medium ☐ Muscular ☐ Obese ☐ Solid ☐ Thin ☐ Height (specify): _____
Hair	Colour	☐ Blonde ☐ Brown ☐ Black ☐ White ☐ Light brown ☐ Grey ☐ Red/Ginger ☐ Auburn ☐ Other (specify): _____
	Length/Style	☐ Short ☐ Medium ☐ Long ☐ Bald ☐ Curly ☐ Straight ☐ Other (specify):_____
Eyes		☐ Black ☐ Blue ☐ Blue/Grey ☐ Brown ☐ Green ☐ Hazel ☐ Grey ☐ Glasses ☐ Other (specify):_____
Facial Hair		☐ Moustache ☐ Beard ☐ Sideburns ☐ Goatee ☐ Shaven
Complexion		☐ Fair ☐ Medium ☐ Dark ☐ Pale ☐ Olive ☐ Tanned ☐ Freckled ☐ Ruddy ☐ Acne/spotted
Hearing		☐ Adequate ☐ Impaired ☐ Hearing aid ☐ Deaf
Distinguishing Features		☐ Tattoo ☐ Scar ☐ Disability ☐ Piercing ☐ Impairment (eg Limp / Mobility Aid) (specify): _____
		Other Features

Details of people who may be able to assist Police to locate the Patient

1. Name	Relationship
Address	Phone
2. Name	Relationship
Address	Phone
GP / Doctor *Print name*	Phone

Incident Information

Date Patient Last Seen	Time Patient Last Seen

Last Seen Location

Possible Destination/s

Description of Clothing When Last Seen

Circumstances of Disappearance e.g. absconded from care, leave etc

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REPORT TO POLICE (PART A)

Mental Health Legal Status *(tick appropriate option)*

	Yes	No	
Voluntary	☐	☐	
Detained Under Mental Health Act 2007	☐	☐	Police Assistance Sought Under: Section 49 ☐
Detained Under Mental Health (Forensic Provisions) Act 1990	☐	☐	Police Assistance Sought Under: Section 68A ☐
Copy of Legal Status Paperwork Attached	☐	☐	

Current concern for this patient

Suicide	Details:
Harm (to self/to others/ from others)	Details:
Other, e.g. illicit drug taking, medical condition, confusion.	Details:

Response / Action Taken By Health Service/Facility *(Tick appropriate option)*

	Yes	No		Yes	No
Patient Contacted by Telephone or Mobile	☐	☐	Absconding Alert Created in eMR	☐	☐
Family / Carer Informed	☐	☐	Registered on IIMS	☐	☐
Facility Grounds & Surrounds Searched	☐	☐	Facility Manager Informed	☐	☐
MH Team Informed	☐	☐	Facility Manager Name:		
Home Address Visited	☐	☐			
Places Patient Known to Frequent Visited	☐	☐			

Please provide any other relevant information (e.g. recent medication administered & side effects; best way to approach and support the patient):

Reporting details – telephone contact with Police must be made prior to forwarding this form

Police Officer Reported to *(Print name)*	Station	Date Time
Email		Phone

Print Staff Name	Designation	Signature	Date

POLICE USE ONLY

COPs entry no: **E:** Uploaded to iVIEW ☐ Yes ☐ No

Instructions: Forward the completed Part A to Police and keep a copy in the patient's medical record. This will assist staff to complete Part B 'Outcome Report to Police.

NO WRITING

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NSW HEALTH/ NSW POLICE MOU ABSCONDED PATIENT

SMR020201

OUTCOME REPORT TO POLICE (PART B)

Telephone Contact With Police Must Be Made Prior To Forwarding This Form

To be completed by Health Facility staff in conjunction with Absconded Patient Report to Police (Part A). Part B is to advise Police that their assistance is no longer required

Date / Time Reported Missing	Health Facility

OUTCOMES

Discharged ☐ Yes Patient Sighted ☐ Yes Patient Located/ Contacted ☐ Yes Patient Deceased ☐ Yes

☐ Patient was NOT Sighted, Located or Returned Date / Time Search Ceased

Notification of Patient's return: Advise Police by telephone immediately if missing patient returns or is located elsewhere or Police assistance is no longer required and forward them this completed form

Patient Returned to Health Facility (Self / MH Team / Family / Carer)	☐ Yes	☐ No		
Patient Returned to Health Facility by Police	☐ Yes	☐ No		
Police Officer's Name (if applicable)			Station	
Date Returned	Time Returned			
Police Notified	☐ Yes	☐ No	☐ N/A (specify)	
Police Officer's Name & Station			Date	Time
Family / Carer Notified	☐ Yes	☐ No	☐ N/A (specify)	
Name			Date	Time
Name			Date	Time
Senior Manager/Executive On Call Notified	☐ Yes	☐ No	☐ N/A (specify)	
Senior Manager's Name			Date	Time
Outcome Recorded in eMR	☐ Yes	☐ No	eMR	
IIMS Finalised	☐ Yes	☐ No	IIMS Number	

Comments

Notifications Completed By

Print Staff Name	Designation	Signature	Date

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NO WRITING