Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB*(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Completeness Review - Mental Health Act Renewal Certificate (Form 2)

- This form is to be placed in the patient's chart.
- The information collected below is used to report on Mental Health Act compliance. Consult with your supervisor/manager as reporting processes may vary by location.

Please include the following information from the Renewal Certificate (Form 2) *(if any of these 3 fields is missing/illegible, please leave that field blank and mark as incomplete later on this form)*	
Date Renewal Certificate (Form 2) issued *(dd-Mon-yyyy)*	Time Renewal Certificate (Form 2) issued *(hh:mm)*
Renewal Certificate (Form 2) issuer ☐ Psychiatrist ☐ Other qualified health professional	

Check the "Incomplete" box if, in your opinion, the information is missing OR illegible upon review of the Renewal Certificate (Form 2)	
Name of the issuing qualified health professional	☐ Incomplete
Business address of the issuing qualified health professional	☐ Incomplete
Issuing professional was identified as Psychiatrist **OR** other qualified health professional	☐ Incomplete
Name of person for whom Renewal Certificate (Form 2) was issued	☐ Incomplete
Date the examination was conducted	☐ Incomplete
Time the examination was conducted	☐ Incomplete
Facts supporting all 4 admission criteria *(a, b, c, and d)*	☐ Incomplete
Indication the facts for all 4 admission criteria *(a, b, c, and d)* were observed by the issuer, and/or communicated to the issuer by others	☐ Incomplete
Name of facility where examination was completed	☐ Incomplete
Date the Renewal Certificate (Form 2) was issued	☐ Incomplete
Time the Renewal Certificate (Form 2) was issued	☐ Incomplete
Renewal Certificate (Form 2) was signed by the issuer	☐ Incomplete

Required Action when any field(s) incomplete: Inform the most responsible QHP
(i.e., the physician or nurse practitioner most responsible for the person's care at time of review)
ONLY a QHP can decide what, if any, corrective actions are to be taken

☐ The most responsible QHP has been notified of the incomplete items noted above

Reviewer Name	Reviewer Signature	Date *(dd-Mon-yyyy)*

Please note that if a new examination is required, the resulting Renewal Certificate (Form 2) will require review as well.