# Emergency closure of a private psychiatric practice: nominated representative form

1. *Person authorised as responsible for practice affairs*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, nominate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to handle the closing of my practice in the unexpected event that this needs to be done on my behalf. The nominee has my permission to access necessary keys and passwords for business records to execute the closure of the practice in a satisfactory manner.

1. *Practice staff*

The following staff should be notified as soon of possible of the emergency closure of my practice to facilitate the notification of patients in a caring, supportive and professional manner.

|  |  |
| --- | --- |
| **Name**  | **Telephone**  |
|  |  |
|  |  |
|  |  |
|  |  |

1. *Patients*

The ready availability of following information is to assist staff to generate letters to inform patients of the practice closure and to identify colleagues who will be able to assist patients (Sample letters for this purpose are available on the RANZCP webpage).

|  |
| --- |
| **Active patients (name, address, telephone number)** |
| Version  | File name and location details  |
| Electronic  |  |
| Hard copy |  |
| Health records  |  |

|  |
| --- |
| **Inactive patients with a retained health record (name, address, telephone number)** |
| Version  | File name and location details  |
| Electronic  |  |
| Hard copy |  |
| Health records  |  |

1. *Professional and practice contacts*

Templates available on the RANZCP website (*Practice staff and service provider and Professional/clinical associations)* for people to notify in the case of practice closure have been populated:

Populated: \_\_\_\_\_ Yes \_\_\_\_ No. Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *Patient Issues*

The following psychiatrists have agreed to handle emergency and prescription needs of my patients on a short-term basis.

|  |  |  |
| --- | --- | --- |
| **Type of cover** | **Name** | **Telephone**  |
| Emergency and prescription needs  |  |  |
| Assist in finding another psychiatrist |  |  |
| Assist in finding another psychiatrist |  |  |
| Assist in finding another psychiatrist |  |  |

1. *Admitting rights*

I have admitting rights and/or affiliations at the following hospitals/clinics. The hospitals should be contacted as soon as possible in the event of a sudden practice closure because I may have inpatients who will need their care transferred to another psychiatrist.

|  |  |
| --- | --- |
| **Hospital/clinic** | **Telephone**  |
|  |  |
|  |  |
|  |  |
|  |  |

1. *Practice medications*

Medications: yes / no. Schedule 8: yes / no.

If yes, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *Prescription pads/paper*

Location of blanks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *Location of business records/bills*

Location of records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of psychiatrist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_