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| **STRICTLY PRIVATE & CONFIDENTIAL****<<NAME RESPONSIBLE CLINICIAN>>****<<ADDRESS>>****<<ADDRESS>>****<<ADDRESS>>****<<ADDRESS>>****<<ADDRESS>>** | Akua AgyepongC/O AMHP Service3rd Floor, Invicta House County Hall Sandling Road Maidstone Kent, ME14 1XX Tel: 03000 415762 Ask for: Akua Agyepong Email: MHGuardianship@kent.gov.uk **<<DATE>>** |
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Dear **<<NAME OF RESPONSIBLE CLINICIAN>>**

**RE REMINDER OF THE EXPIRY DATE OF <<NAME OF PERSON>>’S GUARDIANSHIP**

I am writing to inform you that **<<NAME OF PERSON>>**’sGuardianship (Section 7, Mental Health Act 1983 (as amended)) is **due to expire at midnight on <<DATE OF EXPIRY>>.**

In view of this, please could you arrange for **<<NAME OF PERSON>>**’s needs to be re-assessed as part of a multi-agency review within the next month, if this has not occurred already. As part of this process, it is important you carry out a formal medical examination and decide whether **<<NAME OF PERSON>>** **still requires** Guardianship to enable them to receive the care they need in the community.

If you decide Guardianship is **still needed,** then please complete:

* **the Renewal of Authority for Guardianship – Form G9**

and give it to **<<NAME OF AMHP>>**, Approved Mental Health Professional (AMHP). To help you I have enclosed a copy.

Alternatively, if you decide Guardianship is **no longer needed** then you have the right to discharge **<<NAME OF PERSON>>** and this is effective immediately. However, please do ensure you also complete:

* **Letter of discharge by Responsible Clinician**

and return it as soon as possible so that we can update our records.

**Please note**: it is essential that **<<NAME OF PERSON>>’**s Guardianship is **not allowed to simply lapse**.

Should you require any further information then please don’t hesitate to ask **<<NAME OF AMHP>>** on **<<AMHP’S CONTACT DETAILS>>** or alternatively, contact myself on any of the contact details above.

Yours sincerely

**Akua Agyepong**

**Assistant Director, Countywide Services**

CC **<<NAME OF PERSON>>**

**<<NAME OF NEAREST RELATIVE>>**

**<<NAME OF AMHP>>**

Enc Renewal of Authority for Guardianship – Form G9

Letter of discharge by Responsible Clinician