MHRT USE ONLY – BOOKING DETAILS		
DAY:_____ DATE:_____ TIME:_____	Hearing Room:	☐ LIVE ☐ VIDEO ☐ PEXIP ☐ PAPERS ☐ PHONE

COMMUNITY TREATMENT ORDER HEARING APPLICATION FORM

Civil Jurisdiction – Mental Health Act 2007

PO Box 20764 World Square 2002 | Tel. 1800 815 511
Email: MHRT-Civil@health.nsw.gov.au
Website: www.mhrt.nsw.gov.au

MENTAL HEALTH REVIEW TRIBUNAL

CLIENT DETAILS **MHRT NO:**_____ **MRN:**_____

Surname:_____ Given name(s):_____

Date of birth:_____ ☐ Male ☐ Female ☐ Aboriginal/Torres Strait Islander

Disability: ☐ None ☐ Vision ☐ Hearing ☐ Mobility ☐ Other:_____

Country of birth:_____ Interpreter: ☐ No ☐ Yes – language:_____

Address:_____

Phone:_____ Email:_____

Mental Health Facility:_____ Date detained:_____

☐ Assessable ☐ Involuntary ☐ Voluntary ☐ In Community Date involuntary:_____

☐ **s51 Community treatment order** ☐ **s52(4)(b) – Listing with less than 14 days' notice - best interests**

☐ **s156– Preliminary hearing - access to medical records**

Reason for s52(4)(b)/s156:_____

For information on s52(4)(b) and service of notice requirements, please see Practice Direction 2 of 2023 – Community Treatment Orders which can be found on the Documents page of the MHRT website. For information on s156 please see the Mental Health Act 2007.

Current Order: ☐ None ☐ MHRT ☐ Magistrate Expiry date:_____

Applicant Name:_____ Position:_____ Ph:_____

*The applicant must be an **Authorised Medical Officer** of a mental health facility in which the client is detained or is a patient; a **Medical Practitioner**, a **Director (or Deputy Director delegate) of Community Treatment** who is familiar with the client's clinical condition; the **designated carer** or the identified **principal care provider** for the subject person.*

☐ Client Notified - Date: _____ ☐ In person ☐ By email ☐ By post

☐ Carer Notified - Date: _____ ☐ In person ☐ By email ☐ By post

Declared Community Health Facility:_____

OTHER APPLICATION(S) *(Please refer to the relevant section(s) of the appropriate hearing kit regarding requirements)*

☐ **s44** Appeal against a refusal to discharge

☐ **s46 NSWTGA** Application for financial management order

☐ **s65** Application to revoke CTO

☐ **s67(2)** Appeal against Magistrate's CTO

Hearing Venue:_____

Date preferred:_____ Time preferred:_____

Hearing type: ☐ Live ☐ Video – VMR:_____ ☐ Phone – number:_____

Venue Contact name:_____ Position:_____

Mobile:_____ Phone:_____ Email:_____

Other Notes:_____

Determination Email _____

Distribution List: _____

MHRT USE ONLY – CONFIRMATION OF BOOKING

☐ Applicant advised ☐ Letter posted to client on ___/___/___

☐ Confirmed Date :___/___/___ Confirmed by:_____

☐ MHAS required ☐ Security required

OTHER DETAILS:_____

PLEASE EMAIL COMPLETED FORM TO MHRT-Civil@health.nsw.gov.au