MHRT USE ONLY – BOOKING DETAILS

DAY:_____
DATE:_____
TIME:_____

Hearing Room:

☐ LIVE ☐ VIDEO
☐ PEXIP ☐ PAPERS
☐ PHONE

HEARING APPLICATION

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:_____

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

☐ Forensic patient ☐ Person Under 16 years Date involuntary:_____

Applicant Name*_____ Position_____ Ph:_____

☐ Current Order - Type:_____ Expiry Date_____ ☐ Urgent application

Outcome sought *(inquiry/reviews only)* ☐ IPO ☐ CTO* ☐ FMO

** For CTO outcomes, the applicant must be an **Authorised Medical Officer** of the mental health facility in which the client is detained.*

Declared Community Facility *(CTO outcome only)*_____

☐ **s34** Mental Health Inquiry

☐ **s37(1)(a)** Initial review after mental health inquiry

☐ **s37(1)(b)** 3 mthly review within first 12 months

☐ **s9** Review of voluntary patient

☐ **s101(1)** Consent to surgery

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

☐ **s151(4)** Preliminary hearing re disclosure of evidence

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

☐ **s37(1)(c)** 6 mthly review after first 12 months

☐ **s37(1A)** Review at any other time

☐ **s63** Review of detained person on CTO

☐ **s103** Consent to special medical treatment

☐ **s48** NSWTGA Review of interim FMO

☐ **s156** Application to limit access to medical records

☐ **s94(2)** ECT Administration – involuntary patient ☐ **s93(3)** ECT Consent inquiry – voluntary patient

☐ **s94(2A)** ECT Administration – under 16 years ☐ voluntary ☐ involuntary

*The applicant must be an **Authorised Medical Officer** of a mental health facility in which the client is detained or is a patient.*

Start Date:_____ Finish Date:_____ *Max 6 months* No. Treatments:_____ *Maximum 12* Frequency:_____

The Authorised Medical Officer must do all things reasonably practicable to notify the designated carer(s) and/or the principal care provider of the application for an ECT administration inquiry and to ascertain whether the patient is capable of giving informed consent to ECT - s78(1)(e) Mental Health Act, 2007.

Name(s) and contact numbers for designated carer(s), the principal care provider and other interested persons:

Name:_____ ☐ Notified - Date:_____

Name:_____ ☐ Notified - Date:_____

Determination Email List:
*(list all recipients)*_____

Hearing Venue:_____

Date preferred:_____ Time preferred:_____

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

Venue Contact name:_____ Position:_____

Mobile:_____ Phone:_____ Email:_____

MHRT USE ONLY – CONFIRMATION OF BOOKING

☐ Applicant advised

☐ Confirmed Date :____/____/____ Confirmed by:_____

☐ MHAS required ☐ Security required

OTHER DETAILS:_____

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