

**MHRT USE ONLY – BOOKING DETAILS**

DAY: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> LIVE <input type="checkbox"/> VIDEO
DATE: ____/____/____	<input type="checkbox"/> 4 <input type="checkbox"/> OVP	<input type="checkbox"/> PEXIP <input type="checkbox"/> PAPERS
TIME: _____	<input type="checkbox"/> BOARD	<input type="checkbox"/> PHONE

**COMMUNITY TREATMENT ORDER HEARING APPLICATION FORM**

*Civil Jurisdiction – Mental Health Act 2007*  
 PO Box 247 Gladesville NSW 1675 | Tel. 1800 815 511  
 Email: [MHRT-Civil@health.nsw.gov.au](mailto:MHRT-Civil@health.nsw.gov.au)  
 Website: [www.mhrt.nsw.gov.au](http://www.mhrt.nsw.gov.au)



**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**

Reason for **s156– Preliminary hearing - access to medical records**

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 NSW TGA** 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](mailto:MHRT-Civil@health.nsw.gov.au)**