

**MHRT USE ONLY – BOOKING DETAILS**

DAY: \_\_\_\_\_  1  2  3  LIVE  VIDEO  
 DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  4  OVP  PEXIP  PAPERS  
 TIME: \_\_\_\_\_  BOARD  PHONE

**HEARING APPLICATION**

*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: \_\_\_\_\_

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

Will patient attend hearing?  Yes  No - because \_\_\_\_\_

**CURRENT APPLICATION(S)**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>s34</b> Mental Health Inquiry                              | <b>s44</b> Appeal against a refusal to discharge           |
| <input type="checkbox"/> <b>s37(1)(a)</b> Initial review after mental health inquiry   | <b>s37(1)(c)</b> 6 mthly review after first 12 months      |
| <input type="checkbox"/> <b>s37(1)(b)</b> 3 mthly review within first 12 months        | <b>s37(1A)</b> Review at any other time                    |
| <input type="checkbox"/> <b>s9</b> Review of voluntary patient                         | <b>s63</b> Review of detained person on CTO                |
| <input type="checkbox"/> <b>s101(1)</b> Consent to surgery                             | <b>s103</b> Consent to special medical treatment           |
| <input type="checkbox"/> <b>s46 NSW TGA</b> Application for financial management order | <b>s48</b> NSW TGA Review of interim FMO                   |
| <input type="checkbox"/> <b>s151(4)</b> Preliminary hearing re disclosure of evidence  | <b>s156</b> 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: \_\_\_\_\_ Frequency: \_\_\_\_\_ Maximum 12

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

Name: \_\_\_\_\_ Notified - Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Notified - Date: \_\_\_\_\_

*The Authorised Medical Officer must do all things reasonably practicable to notify the designated carer(s) and 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.*

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** **OTHER DETAILS:** \_\_\_\_\_

Applicant advised \_\_\_\_\_  
 Confirmed Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Confirmed by: \_\_\_\_\_  
 MHAS required  Security required \_\_\_\_\_

**PLEASE EMAIL COMPLETED FORM TO [MHRT-Civil@health.nsw.gov.au](mailto:MHRT-Civil@health.nsw.gov.au)**