

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
 Website: 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
 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)*

- | | |
|---|---|
| <input type="checkbox"/> s34 Mental Health Inquiry | <input type="checkbox"/> s44 Appeal against a refusal to discharge |
| <input type="checkbox"/> s37(1)(a) Initial review after mental health inquiry | <input type="checkbox"/> s37(1)(c) 6 mthly review after first 12 months |
| <input type="checkbox"/> s37(1)(b) 3 mthly review within first 12 months | <input type="checkbox"/> s37(1A) Review at any other time |
| <input type="checkbox"/> s9 Review of voluntary patient | <input type="checkbox"/> s63 Review of detained person on CTO |
| <input type="checkbox"/> s101(1) Consent to surgery | <input type="checkbox"/> s103 Consent to special medical treatment |
| <input type="checkbox"/> s46 NSWGA Application for financial management order | <input type="checkbox"/> s48 NSWGA Review of interim FMO |
| <input type="checkbox"/> s151(4) Preliminary hearing re disclosure of evidence | <input type="checkbox"/> 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: _____ No. Treatments: _____ Frequency: _____
Max 6 months Maximum 12
 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