

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. _____/_____/_____		M.O.
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

**Facility:**

**FORM 4**  
**APPEAL BY PERSON OTHER THAN**  
**PATIENT AGAINST REFUSAL TO**  
**DISCHARGE PATIENT**

**Form 4**  
(Mental Health Regulation 2013 - Clause 7 (2) (a))  
(Mental Health Act 2007, Section 44 (1))

The Registrar  
Mental Health Review Tribunal  
PO Box 2019  
BORONIA PARK NSW 2111

**Appeal by a person other than the patient  
against refusal to discharge a patient**

This appeal relates to .....  
(patient's name)

who is an involuntary patient/a person detained at .....

An application was made to an authorised medical officer for discharge of the patient under section 44 of the *Mental Health Act 2007*.

My name is .....  
(name of appellant)

- I am:
- the applicant for discharge of the patient
  - a person appointed by the patient.

**(Tick one box only)**

I want to appeal to the Mental Health Review Tribunal against the authorised medical officer's:

- refusal to discharge the patient
- failure to make a determination within 3 working days after the application for discharge of the patient.

**(Tick one box only)**

.....  
(Signature)

...../...../.....  
(Date)

Holes punched as per AS2828-1999  
BINDING MARGIN - NO WRITING