


MHRT USE ONLY – BOOKING DETAILS			HEARING APPLICATION FORM		 MENTAL HEALTH REVIEW TRIBUNAL
DAY: _____ DATE: ____/____/____ TIME: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> OVP <input type="checkbox"/> BOARD	<input type="checkbox"/> LIVE <input type="checkbox"/> VIDEO <input type="checkbox"/> PEXIP <input type="checkbox"/> PAPERS <input type="checkbox"/> PHONE	<i>Civil Jurisdiction – Mental Health Act 2007</i> 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: _____
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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: _____

CURRENT ORDER DETAILS	<input type="checkbox"/> NONE <input type="checkbox"/> MHRT <input type="checkbox"/> MAGISTRATE <input type="checkbox"/> CTO – Expiry date: _____ <input type="checkbox"/> VOLUNTARY <input type="checkbox"/> INVOLUNTARY Date detained: _____ Date involuntary: _____ Mental Health Facility: _____
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CURRENT APPLICATION *(Please refer to the relevant section(s) of the [appropriate hearing kit](#) regarding requirements)*

<input type="checkbox"/> s34 Mental Health Inquiry <input type="checkbox"/> s37(1)(a) Initial review after mental health inquiry <input type="checkbox"/> s37(1)(b) 3 mthly review within first 12 months <input type="checkbox"/> s9 Review of voluntary patient <input type="checkbox"/> s94(2) ECT Administration – involuntary patient <input type="checkbox"/> s94(2A) ECT Administration – under 16 years <input type="checkbox"/> voluntary <input type="checkbox"/> involuntary <input type="checkbox"/> s101(1) Consent to surgery <input type="checkbox"/> s46 NSWGA Application for financial management order <input type="checkbox"/> s67(2) Appeal against Magistrate’s CTO	<input type="checkbox"/> s44 Appeal against a refusal to discharge <input type="checkbox"/> s37(1)(c) 6 mthly review after first 12 months <input type="checkbox"/> s37(1A) Review at any other time <input type="checkbox"/> s93(3) ECT Administration – voluntary patient <input type="checkbox"/> s103 Consent to special medical treatment <input type="checkbox"/> s48 NSWGA Review of interim FMO <input type="checkbox"/> s63 Review of detained person on CTO
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☐ **s51** Community treatment order ☐ New ☐ Renew existing

APPLICANT NAME: _____ **TITLE:** _____ **PHONE:** _____

☐ Authorised Medical Officer ☐ Medical Practitioner ☐ Designated Carer/Principal Carer/NSW Guardian
☐ Director Community Treatment ☐ Deputy Director Community Treatment (delegate)

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, the principal carer or the NSW Guardian for the client.

☐ Client has been notified of the application ☐ Carer has been notified of the application

Declared Community Health Facility: _____

HEARING VENUE NAME: _____

Venue address: _____

Date preferred: _____ Time preferred: _____

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

Contact name: _____ Position: _____ Mobile: _____

Phone: _____ Fax: _____ Email: _____

MHRT USE ONLY – CONFIRMATION OF BOOKING <input type="checkbox"/> Notice to be served by: ____/____/____ <input type="checkbox"/> Applicant advised <input type="checkbox"/> Confirmed Date: ____/____/____ Confirmed by: _____ <input type="checkbox"/> MHAS required <input type="checkbox"/> Security required <input type="checkbox"/> Letter posted to client	OTHER DETAILS: _____ _____ _____ _____
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PLEASE EMAIL COMPLETED FORM TO MHRT-Civil@health.nsw.gov.au